



uOttawa

The Chinese Hukou System & its Impacts on Healthcare for Rural-to-Urban Migrants

A Case Study of Tuberculosis Treatment Access in Urban Centres

by

Samantha Veronica Samuels
5202611

A Masters Research Paper Submitted to the Faculty of Graduate and Postdoctoral Studies
in Fulfilment of the Requirements for Obtaining a
Master of Arts in Globalization and International Development

School of International Development & Global Studies
Faculty of Social Sciences
April 2017

©Samantha Samuels, Ottawa, 2017

Table of Contents

Acknowledgements	i
Abstract	iii
Résumé.....	iv
List of Figures	vi
List of Tables.....	vii
Chapter 1: Introduction.....	1
1.1 Context.....	1
1.2 New Initiatives	4
1.3 Problem Statement.....	5
1.4 Limitations and Contributions	7
1.5 Research Paper: Structure.....	7
Chapter 2: Literature Review & Theoretical Applications	9
2.1 The Hukou System	9
2.1.1 The Hukou System: A Brief History	9
2.1.2 The Hukou System: Function and Practice.....	10
2.2 Chinese Urbanization	13
2.2.1 Rural-to-Urban Migrant Integration: The Effects of Hukou on Equal Urbanization.....	14
2.2.2 China's New Urbanization Plan: 2016-2020	15
2.3 China's Healthcare System: An Historical Overview	17
2.3.1 Healthcare Access	19
2.3.2 Who Benefits from Healthcare?	22
2.4 Theoretical Applications	24
2.4.1 Critical Urban Theory	24
2.4.2 Understanding the Right to the City & Spatial Justice.....	25
2.4.3 Confucianism	27
Chapter 3: Research Framework & Methodology.....	30
3.1 Research Framework.....	30
3.1.1 Research Questions	30
3.1.2 Conceptual Model	32
3.1.3 Conceptual Model – Explanation.....	35
3.2 Research Methods.....	36
3.2.1 Site & Case Study Selection.....	36
3.2.2 Methods	37
Chapter 4: Data Collection, Results, and Discussion.....	39

4.1 Data: Collection & Results.....	39
4.1.1 Tuberculosis & Migration: Overview.....	39
4.1.2 Characteristics of New TB Migrants	42
4.1.3 Factor 1: Initial Health Seeking (IHS) Behaviour	44
4.1.4 Factor 2: Ability to Recognize TB Symptoms.....	46
4.1.5 Factor 3: Cost as a Deterrent Factor for Seeking Treatment.....	48
4.2 Discussion & Interpretation.....	51
4.2.1 Problem 1: The Hukou System – Current Agenda?	52
4.2.2 Problem 2: Economic Decentralization & the Structure of the Healthcare System	53
4.2.3 Problem 3: Equal Healthcare Access as Right to the city – Revisiting the Conceptual Framework.....	56
Chapter 5: Conclusion – Continued Reform for a Better Urban Future.....	61
5.1 Summary of the Research Findings.....	61
5.2 Challenges for Consideration.....	63
References.....	66

Acknowledgements

I could not imagine the completion of this master's research paper without the utmost level of support that I received from my family, friends, and colleagues. I first and foremost extend the abundance of my gratitude to my supervisor, Dr. Huhua Cao, whose enthusiasm, humour, wisdom, and never-ending support were there to motivate me when my spirit was waning. He is the most dedicated professor I know, not just to his own work, but to his students.

While the committee for a master's research paper is small, I would like to thank my second reader, Dr. Melissa Marschke Redwood, who has always been dedicated and more than open and willing to answering any questions I may have had throughout the process, as well as for teaching me about the requirements of a major research paper in my first year in the master's program.

I also owe some of this accomplishment to my employer, Steve Geffin, whose understanding and support of the completion of this paper and my degree I am exceptionally grateful for; there are few employers who fit this description.

For the more detailed parts of this paper, specifically the creation of the table of contents, as well as the lists and my conceptual model, I owe many thanks to my friend Brittany MacDonald-Alleyne, whose enthusiasm and eagerness to help made this process a lot less stressful than it would otherwise have been.

I would once again like to thank Dr. Cao for making me part of his "team," as he likes to call it, and for making me an integral part of the project management and preparation process for the 2015 International Conference on Chinese and African Sustainable Urbanization, held here on

our campus. It was a most rewarding experience, the basis of many new-founded friendships, and offered many revelations for this research topic.

I extend many thanks to my colleagues, and to the admin at the School of International Development and Global Studies, especially Katherine Belley and Tiffany Carrière who have been especially helpful throughout the administrative process in completion of this program.

I would like to thank my mother, whose unending faith in me and encouragement was the most powerful source of inspiration when I questioned my capabilities and underestimated myself.

Last, but certainly not least, I would like to thank my guiding light, Patrick Salenius, for being the energy, support, and unconditional love that I required to get through this. I know you shall be there for me throughout all triumphs and tribulations.

Abstract

China's current healthcare system is rooted in the Hukou system, which is the household registration system based on an individual's place of birth. The Hukou system served as a form of migration management for the Chinese government since 1958, specifically by helping to separate the agricultural and industrial sectors to facilitate the objectives of the socialist planned economy. Furthermore, this period of economic liberalization also resulted in the reform of the Chinese Hukou system. This new era prompted waves of migration from the rural countryside to urban centres in the hopes of prosperity and a path out of poverty. However, the legacy of the Hukou system still maintained the spatial hierarchy between urban residents and rural migrants, resulting in inequality and marginalization for rural-to-urban migrants, specifically regarding social benefits, such as equal healthcare access. Today, while those with rural Hukou living in cities receive medical care, the quality, efficacy, and cost of obtaining it are unequal between rural migrants and urban residents. This paper will explore the Hukou system's legacy and its implications on China's healthcare system. In doing so, it will aim to answer how the Hukou system, despite reform, impacts rural-to-urban migrant healthcare access; how migrant healthcare access compares to accessibility for those with urban Hukou, and furthermore; how this spatial inequality created by the Hukou system infringes on migrants' *right to the city* by creating barriers to obtaining equal, reliable, and affordable healthcare. The research employs the use of a literature review, manual literary coding techniques, the application of Critical Urban Theory, the selection of tuberculosis as a case study to examine the variance in healthcare accessibility between rural migrants and urban residents. This will demonstrate that migrants do not have equal healthcare access due to their Hukou status, and therefore an unequal *right to the city*.

Résumé

Le système des soins de santé actuel en Chine est enraciné dans le système Hukou, qui est un système d'enregistrement des ménages basé sur le lieu de naissance d'un individu. Le système Hukou a servi au gouvernement chinois comme une forme de gestion de la migration depuis 1958, notamment en aidant à séparer les secteurs agricole et industriel pour faciliter les objectifs poursuivis. La fin de cette révolution culturelle marque le début d'une libéralisation économique de la Chine, ayant entraîné une réforme et une détente, surtout lorsqu'elle visait le système Hukou. Cette nouvelle ère incite l'exode rural dans l'espoir d'un épanouissement personnel. Cependant, l'héritage du système Hukou a maintenu la hiérarchie spatiale entre les citadins et les migrants ruraux, créant des inégalités et une marginalisation des migrants issus de l'exode rural, particulièrement en ce qui concerne les avantages sociaux, telle que l'égalité d'accès aux soins de santé. Pendant qu'aujourd'hui ceux inscrits au Hukou rural et vivant dans les villes reçoivent des soins médicaux, la qualité, l'efficacité et le coût de son obtention restent inégaux entre les migrants ruraux et les citadins. Cet article explore l'héritage du système Hukou et ses impacts sur le système des soins de santé du pays. Pour cela, nous visons à répondre aux questions suivantes: 1) comment le système Hukou, en dépit de la réforme, impacte l'accès aux soins de santé des migrants issus de l'exode rural; 2) Comment l'accès aux soins de santé des migrants se compare à l'accessibilité pour les titulaires d'un Hukou urbain? 3) Comment l'inégalité spatiale créée par le système Hukou porte atteinte au droit des migrants à la ville en générant des obstacles à l'obtention des soins de santé équitables, fiables et abordables. Notre recherche utilise une revue de littérature substantielle, des techniques manuelles de codage sur cette littérature et le choix de la tuberculose comme étude de cas pour examiner la variance de l'accessibilité des soins de santé entre les migrants ruraux et les citadins. Comme résultat, cela démontre que les migrants n'ont pas un accès équitable aux soins

de santé en raison de leur statut Hukou et, par conséquent, ont un droit inégal à la ville, d'après la théorie d'Henri Lefebvre.

List of Figures

Figure 3.1.2 - Conceptual Model 34

Figure 4.1.3 - IHS patterns of migrants 45

Figure 4.2 - Conceptual Model: Revisited 58

List of Tables

Table 4.1.2 - Social demographics of migrants with new incidences of TB.....	43
Table 4.1.3 - Rate of delay in seeking medical attention for TB symptoms.....	44
Table 4.1.4 - TB knowledge of migrants versus residents.....	47
Table 4.1.5 - Medical expenditure on TB treatment	49

List of Abbreviations

DOTS	Directly Observed Treatment Short-course
EHA	Equal Healthcare Access
IHS	Initial Health-Seeking
MDR-TB	Multi-Drug-Resistant Tuberculosis
MTB	Mycobacterium Tuberculosis
NCMS	New Rural Cooperative Medical Scheme
RTC	<i>Right to the city</i>
SID	Supplier-Induced Demand
TB	Tuberculosis
UEBMI	Urban Employee Basic Medical Insurance
URBMI	Urban Resident Basic Medical Insurance

Chapter 1: Introduction

1.1 Context

China has undergone rapid urbanization over the last four decades that has resulted in the mass migration of people living in rural areas to more urbanized areas in the country. Migration has increased as a result of decollectivization,¹ which resulted in the diaspora of many rural workers from the agricultural sector. This era of decollectivization and reform was responsible for the release of an excess of rural labourers in the agricultural sector, inevitably leading them to look for non-agricultural work (Young, 2013). With this also came the reform of urban state-owned enterprises (SOEs), as well as the growth of private enterprises and markets, which permitted rural migrants to survive and participate in urban economies, encouraging migrants with an incentive to improve their economic livelihood through urbanization (Cao *et al.*, 2000). This economic incentive to establish a better standard of living propelled a surge of migrants towards more urbanized areas.

Despite the process of decollectivization and the transition to a market economy, the implications of the Hukou's function to maintain a spatial hierarchy of the rural countryside versus urban city centres is an enduring testament to the pre-reform period. The Chinese Hukou system functioned, and in some ways, continues to function, as a roadblock to individual advancement. A legacy with approximately 2000 years of history, the Hukou system is perhaps the most influential and the most durable legacy as a part of the Chinese socialist control instruments. In the Chinese context, Hukou is the method of official identification implemented by the State which prescribes

¹ Referring to the decollectivization of China's rural economy in the early 1980s, one of the most significant aspects of the country's transition to a capitalist economy. The term is defined as a transition from a socialist economy to a market economy (Xu, 2013: 17).

rights based primarily on an individual's place of birth, as well as their place of residence. The local public security bureaus implement the Hukou as a means of controlling population movement and migration patterns, which, while it may no longer necessarily impede mobility rights, infringes on the socioeconomic benefits of rural migrants who have moved to urban areas (Young, 2013). This is evidenced by the fact that citizens are divided into the categories of "urban" and "rural," and that the same social benefits do not apply to everyone.

The Hukou system requires that each citizen hold a residency status in only one place of permanent residence, and individual Hukou is determined by the individual's place of birth, in either the city or rural countryside. Transfer of an individual's permanent Hukou from one locale to another would require official state approval, which requires meeting several conditions (Zhang & Tao, 2012). Consequently, the place in which one's permanent Hukou registration holds validity, according to government policy, is the only place in which the individual can claim any attainable rights, especially pertaining to socioeconomic benefits. Among these benefits is healthcare accessibility, which is distributed via three health insurance tiers under the country's basic medical insurance program. Since rural-to-urban migrants do not reside in their locale of origin, equal healthcare access for rural-to-urban migrants in urban areas, while having improved by way of reforms, has been a problem.

As the economic reforms signalling the end of the Cultural Revolution² came underway, migrants continued to move towards urban centres, resulting in the continued unequal distribution between the migrant population and urban residents (Milcent, 2010). Since access to the current

² Officially the Great Proletarian Cultural Revolution, the Cultural Revolution was a social uprising instigated by Chairman Mao Zedong during his final decade in power (1966-1976) which was designed to steer China the path of the Soviet Revolution, which Mao believed went astray. It consisted of a mass mobilization of the country's urban youth, and designed to oppose "bourgeois infiltrators" in his party – those who did not have the same vision of communism. This resulted in substantial violence and shrinkage of industrial production, considered to be a dark time in Chinese history (Lieberthal, 2016).

basic healthcare system in China is based on one's Hukou status, and considering that Hukou is not easily transferrable from one status to another, rural-to-urban-migrants face barriers accessing services in the country's basic healthcare system, specifically in urban centres. While in principle, rural-to-urban migrants employed in urban centres can access health insurance provided by their place of work, employers are often reluctant to insure them (Zhao *et al*, 2014). This lack difficulty infringes upon rural-to-urban migrants' rights to access healthcare services otherwise more easily accessible by residents with urban Hukou. While this might not directly deter rural residents from moving to urbanized areas, it poses a threat to their living a well-integrated and healthy life.

It is important to note that for the purposes of the research, the definition of the "migrant" label will refer exclusively to **rural-to-urban** migrants or **rural-migrant workers** (*nongmingong*³). This definition is important, as it provides a distinction between urban migrants moving to either another urban area or a rural area outside of their current residence. Thus, the objective of this research paper is to examine the impacts and implications of the Chinese Hukou system on rural-to-urban migrants. The research paper aims to establish that the Hukou system has created a context of inequality and marginalization for migrants specifically where it pertains to healthcare accessibility. The research acknowledges through review of the literature that while the Hukou system has achieved significant improvement in the country over the last few decades since China's decollectivization process, its legacy is still embedded in various policies, making what should be equal access to basic healthcare an unnecessarily complicated process for rural-to-urban migrants.

³ Zhuo Mingchao (2016) translates *nongmingong* as rural "migrant workers" in the city. They are typically defined as such in public policy documents, media, and everyday language. Mingchao states that *nongmingong* are not only viewed as a source of cheap labour for industrial employers, but are also seen as the "Other" in Chinese urban society.

1.2 New Initiatives

Since the 1990s, China has concretized and expanded previous Hukou reforms. According to the U.S Congressional-Executive Commission on China (2016), some of these reforms include the national easing of limits on migration in small towns and cities, streamlining the registration of Hukou in some provinces and larger cities, as well as several local reforms in various areas across the country. However, during the Commission's 2016 reporting year, it was determined that the Chinese government persisted, using the Hukou system, to complicate freedom of mobility and residence. The reforms do not represent a complete abolition of the Hukou system; instead, they purport to eliminate some of the divide that the Hukou creates by only removing some Hukou categories. New migrants are still required to meet strict criteria to be granted transfer of their Hukou to a new area, and for the most part, these criteria exclude Chinese migrants, such as those working in manual labour and living in temporary accommodations (Congressional-Executive Commission on China, 2016).

While Hukou policy has merely been relaxed and not formally abolished, in March 2014, China launched its much-anticipated new urbanization plan, titled *China's New-type Urbanization Plan, 2016-2020*, focusing on the more human components of the country's rapid urbanization process. The plan aims to further reform the Hukou system, specifically by registering some 100 million new urban Hukou over a six-year span. However, the only beneficiaries of the extended Hukou will be those no longer involved in the agricultural sector, and only college-educated and skilled workers, as well as long-standing migrants, will be prioritized (Chan, 2014).

While China's new urbanization plan has objectives worthy of embarking on for the continued and sustainable urbanization of the country, literature pertaining to the implications of Hukou on migrant *rights to the city* in the context of the urbanization process is very limited. The

presence of such literature would be beneficial to continued reform of the Hukou system, specifically by including the component of more progressive rights, especially within the context of China's continued and rapid urbanization. Such literature is fundamental to reorienting the conversation on migrant rights, and to shifting the paradigm when considering these rights in the context of migration and mobility policy, placed within the larger context of urbanization. This shift is imperative to the formation of new initiatives for more liberal reform – ideally, the abolition of the Hukou system altogether. This shift is also imperative if China wishes to equalize the accessibility of healthcare and other social services between rural migrants and urban residence. To assist in reorienting the conversation and shifting the paradigm, this research paper aims to highlight the importance of spatial justice in China, if not to eliminate the Hukou system altogether, to continue reform and to further close the healthcare accessibility gap between rural-to-urban migrants and urban residents.

1.3 Problem Statement

This research paper presents and outlines the continued problem that Hukou policy creates for migrant healthcare access in urban centres. The relationship between China's Hukou system and urbanization can be identified as the inaccessibility of basic social welfare benefits for China's floating population in urban centres. This is because while Hukou policy has relaxed, urban Hukou is difficult for rural-to-urban migrants to obtain due to strict criteria that is difficult to obtain in the first place. This prevents an equal and proper integration of these migrants into cities, creating a situation of displacement and alienation of Chinese citizens in their own country. While Hukou policies were implemented over 50 years ago, and despite China's liberalization reform since the late 70's, marginalization is still felt today by China's most vulnerable population.

The problem facing China's rural-to-urban migrant workers that this paper will focus on is their inability to access quality healthcare in urban centres. The classification of health insurance is three-tiered, designating healthcare access based on an individual's Hukou status. The Hukou is automatically tied to an individual's maternal county or locale at birth, including their access to healthcare. Therefore, a person of rural Hukou is bound to their rural Hukou even though they might live, work, and have made substantial contribution economically in terms of productivity.

In exploration of the above-outlined problem facing rural-to-migrants and their ability to access healthcare in cities, the research will employ literature pertaining to spatial justice to discuss how the Hukou poses a threat to rural migrants' *right to the city*, as developed by Henri Lefebvre. While this literature might appear misplaced, given the non-democratic context of the People's Republic of China, the "Marxist roots of Lefebvre's theory, which sought to transform the ability of local residents to appropriate and contribute to governance in cities, is consistent not only with China's communist political foundations, but also its political thought" (Weiler, 2015: 5). The research presented aims to employ two main areas of theory, which are 1) critical urban theory, and 2) Confucianism, to make the application of critical urban theory more relevant to the Chinese context. In application of these theoretical perspectives, this research paper aims to create a better understanding of how the Hukou system's role in a continuously modernizing and urbanizing China segregates and marginalizes *nongmingong*, infringing on their rights to 'urban benefits,' and thus their fair and equal *right to the city*.

1.4 Limitations and Contributions

The research paper acknowledges that the overall topic is vast, with substantial room for exploration and elaboration on the key themes and topics involved, specifically the Hukou system, urbanization (both within China and globally), China's healthcare system, tuberculosis as an infectious disease of poverty, and Critical Urban Theory. Therefore, it should be kept in mind that the scope and space of the paper does not allow for much room to elaborate, and therefore does not do each of these topics justice.

While it is acknowledged that there are some limitations to the research, it is worthwhile to consider the research's contributions to both existing and non-existing literature. The value of this paper is that it offers a unique analysis, linking the problems of the Hukou system to healthcare accessibility issues, further linking this problem to Critical Urban Theory; none of the literature selected during the literature review process provided this type of analysis. Specifically, there is extensive literature on China's Hukou system and its impact on healthcare accessibility; however, none of the other consulted publications explored the issues from a theoretical level of analysis. The paper also acknowledges the importance of connecting Confucianism to the Western theories explored throughout the paper, which provides further depth and quality to the analysis. The hope, therefore, is that the research paper will contribute to existing literature, providing a unique linkage of the practical and the theoretical.

1.5 Research Paper: Structure

This research paper will consist of five chapters. The purpose of this introductory section as the first chapter is to provide the contextual basis for the rest of the paper, describing the historical context and outlining some of the main issues pertaining to Hukou and healthcare

accessibility for rural-to-urban migrants. The second chapter will concentrate on the review of literature which will focus on the following four themes: (1) the Hukou system and its evolution; (2) urbanization, its relationship to the Hukou system, and the integration of rural migrants in urban centres; (3) the evolution of the Chinese healthcare system, and the Hukou's implications on migrant healthcare access; and furthermore, (4) the implications of unequal healthcare distribution on migrant's integration to urban centres, and on their *right to the city* and spatial justice, according to critical urban theory. The third chapter will present and elaborate on both the research question to be explored, the methods employed to conduct the research, as well as the conceptual framework, and how the research questions tie into this framework. This chapter will also discuss the motivations behind both the topic and the chosen theoretical framework. The fourth chapter will provide data from various case studies focused on tuberculosis treatment in China. In presenting these case studies, the chapter will also provide room for discussion on the findings, as well as for the application of the theoretical underpinnings. This section will serve as the venue to connect the theoretical framework to the context of Chinese rural-to-urban migrants and their experience with accessing healthcare services within the country. The analysis will also demonstrate the roles that the theoretical application of the *right to the city* and spatial justice have on healthcare policy. In so doing, the analysis will also highlight the importance of further reforming the Hukou to achieve a more equal society. Following this, the paper will offer a conclusion to both summarize the research findings, and to offer other considerations on the objectives for new initiatives and good governance practices.

Chapter 2: Literature Review & Theoretical Applications

This chapter will be dedicated to the literature review based on the themes of the Hukou system as an institution, its relationship to urbanization, and the Hukou system's imposition on equal access to adequate healthcare for rural-to-urban migrants. In addition, the chapter will also review the key concepts for analysis, which are equal healthcare access, spatial justice, and the *right to the city*.

2.1 The Hukou System

2.1.1 The Hukou System: A Brief History

The Chinese Hukou system is commonly known as the ultimate policy on migration control in China, and is recognized by scholars as the “major institutional pillar underlying the deep rural-urban chasm in China in the last half century” (Chan, 2009). The origins of the Hukou system evolved out of what was traditionally known as the *baojia*⁴ system of population registration and mutual surveillance used as a pre-1949 system of control in the countryside (The China Quarterly, 2000: 908). However, its transformation to its modern-day characteristics is a result of 20th century techniques of social control that were perfected under the communist-led revolutionary base areas during the pre-reform period (Cheng & Selden, 1994). The modern-day Hukou system, initially influenced by the Soviet *propiska*, was regarded as a component of Chinese socialist economic planning, designed to deter rural-to-urban migration (Kuang & Liu, 2012: 1).

⁴ The *baojia* system was a system used to administer local registration. It was developed by Wang Anshi, economist, statesman, and chancellor during the Song dynasty (Mote, 2003).

The Hukou system gradually evolved following Mao Zedong's⁵ rise to power as the political leader of the Communist Party and the beginning of the Cultural Revolution (Alfridi, *et al.*, 2014).

2.1.2 The Hukou System: Function and Practice

After the solidification of the Communist Party, the Hukou system was first reintroduced as a practice in 1951, with the purpose of documenting the residence of the urban population, and to find any remaining anti-government elements (Chan, 2009). In 1955, the government realized that rural-to-urban migration would forestall the State's attempt to develop an urban welfare state, and as such prevented this by dividing the population into agricultural and non-agricultural sectors. Chan & Zhang (1999) argue that this was done first to control mobility and residency of the urban populace, and then extended to cover both the rural and urban population, a practice becoming fully implemented and utilized by the government in 1958. In its initial structure during Chairman Mao's incumbency, Hukou policy classified the population into two distinct categories, which were the rural and urban householders (Chan & Tsui, 1992) for the purposes of industrialization in the urban sector. According to Chan (2010), the urban class worked in and prioritized the industrial areas for the benefit of access to social welfare benefits and full urban Hukou, while the rural or peasant class was relegated to the countryside to produce agricultural surplus to support and provide for the urban residents, with few, if any, benefits. This manipulation of the Hukou system was seen by the government as a crucial component to the achievement of socialist ends, specifically during the pre-reform period. The development of a socialist planned economy, modeled after that of Russia's, relied on this division between rural and urban areas because socialist

⁵ Mao Zedong was one of the most influential political figures of the People's Republic of China. He became chairman of the Communist Party in 1943, and was responsible for the revolutionary transformation of the country by means of land reform, collectivization, industrialization, and the comprehensive politicization of everyday life (Davin, 2013).

modernization and industrialization was seen as an urban project, literally fed by the rural populace (Young, 2013). This segregation prompted by state favouritism was important for the government's achievements in the revolution by constructing a "spatial hierarchy," whereby urban residents received preferential treatment in terms of receiving government-subsidized benefits, such as education, social and medical services (Chan, 2009). The Hukou system proved as a functional tool in the process by "controlling the population movement up and down the spatially defined status hierarchy, [ultimately] preventing population flow to the largest cities, enforcing the permanent exile of urban residents to the countryside" (Cheng & Selden, 1994). Additionally, this period experienced strict controls on rural outflow, along with many similar tactics aimed at controlling rural residents, such as the collectivization of farmland, prohibiting the use of farmland for any non-agricultural purposes; ultimately these measures effectively circumscribed rural residents' access to economic, social, and political opportunities and rights (Chan, 2010: 358).

The most notable function of the Hukou system used during socialism's industrialization strategy is that the industrial sector was assigned priority to China's economic development, and was nationalized. In contrast, the rural/agricultural sector treated as a 'residual,' serving its main functions as the protector of raw goods, labour, and capital for the urban-industrial centres (Chan, 2009). The agricultural population was primarily excluded from state-supplied benefits, and had no rights to any state-owned, national resources, having to fend for themselves while producing and supplying for the urban-industrial sector (Witon, 2013). Not only did the rigid implementation of the Hukou system facilitate for this spatial hierarchy of urban over rural, but it also served to both register and infinitely bind an individual to their place of birth, linking the order of the individual and the family to the order of the state (Cheng & Selden, 1994). Ultimately, the Hukou

system was not only a tool for migration management, but also a way for the State to have full surveillance and control of mobility.

While the Hukou system's impacts on rural residents prior to reform prevented self-advancement, throughout its evolution, the government has made many beneficial policy changes to the Hukou system, which have resulted in positive changes for migrants that came the commencement of major economic reforms in 1978 (Xu, 2011). During this time, the demand for labour increased significantly in the urban sector, and with it, the regulations controlling mobility, including the Hukou system itself, were gradually relaxed to encourage movement into urban zones (Cui & Cohen, 2015).

Despite the fact that the Hukou system still functions as the tool for the control and surveillance of mobility and migration in the country, its evolution demonstrates gradual and continuing reform; however, the large-scale migration of rural residents to cities since the beginning of Hukou relaxation has not presented much change in the institutional framework of Hukou policy, which was designed maintain the rural-urban divide (Chan & Buckingham, 2008). These reforms still work in the favour of urban residents, even migrants who have resided in urban centres for some time. This is demonstrated in *China's New-type Urbanization Plan, 2016-2020*, initiated in 2014, which plans to urbanize 60% of the country's population, creating a 45% Hukou population in urban centres by its completion year, 2020, suggesting a decrease in the rural-urban gap by 15% by the final year of the Plan (Chan, 2009). While this is a significant increase in rural-to-urban integration, this will maintain and create a new existing gap with a third category, between urban residents, those with new urban Hukou, and rural residents who continue to migrate to urban centres.

2.2 Chinese Urbanization

Urbanization is a complicated process that involves the migration of a population from a rural to urban areas, as well as converting land from rural to urban, the spatial configuration of settlements, as well as transformed governance structures (Gu & Wu, 2010). The United Nations (2014) connects urbanization to three pillars of sustainable development, specifically economic, social, and environmental development.

According to the United Nations' 2014 report on urbanization, at present there are far more people living in urban areas than in rural locations, with approximately 54% of the world's population living in urban areas as of 2014. This is a large jump, considering in 1950, only 30% of the global population was considered urban. (United Nations, 2014). By 2050, the UN projects that the global urban population will reach 66% (United Nations, 2014). Furthermore, we can see that while the rate of the world's rural population reached its peak in 1950, we are witnessing a gradual decline, demonstrating that urbanization is an ongoing and continuously evolving process.

Urbanization has and continues to impact and change the lives of Chinese people. Since the era of decollectivization and post-Mao reorientation economic reform, the severed ties between industrialization and urbanization has been somewhat restored as a continuous flow of migrants and their families pour into urban areas, aiming to gain entrepreneurial success and looking for work (Chang, 1994). This was a spurred reaction to failed Maoist economic policies during the Cultural Revolution, resulting in the establishment of a market economy in the economic reform period. In the approximately three decades since the beginning of economic liberalization, "China's urban population has risen by more than 500 million, the equivalent of America plus three Britains," and "by 2030, China's urban population is expected to increase to a staggering 1 billion people – about 70% of China's population, and roughly an eighth of humanity" (The

Economist, 2014). As the urban population climbs, the rural population continues to shrink. According to World Bank data (2016), the rural population in China has seen a steep decline within the last five years, decreasing from 49% of China's population in 2011 to 46% in 2014, an indication that the world's rural population is continuously shrinking.

2.2.1 Rural-to-Urban Migrant Integration: The Effects of Hukou on Equal Urbanization

Certainly, human migration is both a complicated and stressful phenomenon for those having to relocate. This experience can have potentially harmful ramifications on ones' physical and mental health. Specifically, the strain of the migration process itself, combined with an absence of social support, an inconsistency between achievement and expectations, economic hardship, social discrimination, poor housing, and lack of access to medical care may lead to poor self-esteem, poor self-efficacy, and mental health issues in vulnerable individuals, according to Wang *et al.* (2010). Many rural-to-urban migrants endure stigmatization from their urban counterparts, and are severely marginalized into the peripheries and outskirts of urban life.

Moreover, it is very difficult for those coming from rural areas to acquire an urban Hukou despite working in and contributing to the urban economy, making integration very challenging for the individual in question. While migrants face discrimination and segregation pertaining to social benefits provided by the state, they also encounter a great lack of social integration. Residents born with urban Hukou perceive rural-to-urban migrants as having poor education, backwards, lacking in hygiene, and as having a higher likelihood of engaging in criminal activity. This level of stigmatization inspires valid uncertainty in migrants pertaining to protection from arbitrary costs, personal safety, as well as arbitrary bureaucratic procedures (Wang & Zuo, 1999). Perceived as 'outsiders,' migrants are segregated by the urban population, and are viewed as 'rustics,' are negatively portrayed, and endure ill treatment at work; migrant are typically

employed in what are known as the notorious ‘3D’ jobs,’ meaning work that is dangerous, dirty and demeaning (Guan & Liu, 2014). These jobs typically include construction, manufacturing, and low-end services, fundamentally jobs that demand hard manual labour, with unequal pay for work, which limits migrants’ opportunities for finding jobs in the formal employment sector (Wang & Fan, 2012). Since migrants are underpaid for their labour, they are at a notable disadvantage of competing in China’s continuously and rapidly emerging housing market, in addition to the Hukou-based institutional barriers that create obstacles for their access to the urban housing system (Liu *et al.*, 2013); this results in having to contend with living in slum conditions and dealing with overcrowding in typical migrant housing hubs in the cities.

2.2.2 China’s New Urbanization Plan: 2016-2020

While China still has much progress to make in reducing, if not eliminating, discrimination against migrants, it is making strides to improve migrant integration in the urbanization process. In March 2014, China unveiled its new urbanization plan titled *China’s New-type Urbanization Plan, 2016-2020*. The *New-Type Urbanization Plan* consists of 17 major policy goals across four different areas of urbanization (Shao, Mizuho Bank, 2016), itself is dedicated to the achievement of a more ‘humanized’ urbanization process, placing a stronger emphasis on fundamental issues, such as urban-rural integration, the acceleration of agricultural modernization, an emphasis on food security and safety, as well as the encouragement of reforms of the Hukou system rather than just the development and modernization of hard infrastructure. The document also outlines that it intends to introduce an additional 100 million new residents to cities by 2020 (Chan, 2014), implying newly migrated residents.

There are various interpretations of the government's intentions with the *New-Type Urbanization Plan*. One argument is that while the government aims to accomplish urbanization objectives with a more human-centred focus, specifically by attempting to drastically reduce the number of the floating population, some argue that the State's primary goal is for economic transformation. The logic is that since migrant workers rarely obtain urban Hukou, they are underpaid, and therefore tend to live frugally to save their earnings, which is said to be one factor for the country's abnormally high ratios of savings and investment, and inevitably a roadblock to a strong and sustainable economy (Johnson, 2014). By virtue of this, it is suggested that by granting urban Hukou to the target number, these people will finally have improved rights, including access to higher paid employment, therefore leading to more spending and less saving, thereby boosting the economy.

While there are several other critiques of the *New Urbanization Plan*, addressing them all is beyond the scope of this paper. It is in fact important to acknowledge that not only is Hukou policy relaxing, but that there are three other key policy modifications that will change the lives of China's migrant workers: 1) Local governments will extend basic public services, such as extending equal education opportunities for 99% of migrants by the deadline; 2) Achieving a more sustainable urbanization by focusing on improving urban infrastructure, resources and the environment, as well as increasing public transportation by 60%; 3) as well as tackling the long-existing regional disparities between the eastern, central, and western regions of the country, favouring a better regional balance in terms of spatial distribution and scale structure (Wang *et al.*, 2015).

However, while the plan aims to extend urban Hukou to a large population of existing migrants in urban centres, the plan continues to exclude migrants still involved in agriculture,

either in rural locales or in urban centres. Specifically, those who are still considered to be involved in farming, including many current migrants who have still possess farmland back home, will not be extended urban Hukou.; college-educated and skilled workers, and longer term migrants will receive priority for urban integration (Chan, 2014). This shows that the government still has work to do in terms of fully integrating those with rural Hukou and rural-to-urban migrants who are still involved in the agricultural sector.

While there are still and will always be improvements to be made, it is also evident that the country is making great strides in creating a more inclusive urbanization process for migrants, which we hope will become more inclusive and sustainable with time and continuous reform.

2.3 China's Healthcare System: An Historical Overview

While incomes and quality of life have improved for many with economic reforms since the 1980s, the quality of healthcare has deteriorated for the majority of the population throughout the country's post-reform period. There are increasing numbers of residents that experience health problems resulting from different causes, such as stress from intense work environments, environmental pollutants, lack of quality food safety and security policies, as well as communicable diseases (Zheng *et al.*, 2015: 449). In order to understand China's current healthcare policies, which influence healthcare access, it is useful to examine the country's healthcare system prior to reform and onward. Plans to reform the country's healthcare system began at the beginning of the twenty-first century as a result of a steady deterioration in the scope and quality of healthcare services due to drastic market reform (Kahler, 2011: 50).

It is instructive to compare China's healthcare system between the founding of the PRC in 1949 and the economic reforms and liberalization policies that took place in the early 80s (Li,

2011) to understand the position of the country's current healthcare dynamics. Within the first 30 years of the PRC's establishment, China had many notable accomplishments pertaining to its healthcare system, particularly universal healthcare, facilitated by a low-cost wide-coverage primary healthcare model; healthcare was often very affordable, if not free in public hospitals in urban areas, and there were good strategies for disease prevention (Li, 2011).

The healthcare system of China's pre-reform period is identified by a sharp divide between the rural and urban populations, with three distinct healthcare provision schemes, two for those with urban Hukou, and one for those with rural Hukou (Cooper, 2016). During the pre-reform period, residents of rural China were provided healthcare under what was known as the Cooperative Medical System, which provided clinics that were publicly funded, and also funded the practice of more than 1.76 million "barefoot" doctors (Banister, 1987). In the countryside, barefoot doctors provided affordable healthcare to farmers, and were deemed to be one of the most important successes of the Maoist era, specifically for the purposes of the Revolution, as the new ideology required strong men and women for a new China (Zhou, 2016). Barefoot doctors were amateur healthcare practitioners and expert revolutionary actors for the Revolution's propaganda, crucial to the Revolution's task force in providing healthcare to rural villages; however, these "doctors" had no formal training (Li, 2015: 3-4). During the beginnings of the Cultural Revolution, thousands of peasants, consisting of men and women in their 20s with some basic education were put through a three-to six-month intensive medical school, where they were taught things such as anatomy, bacteriology, diagnostics, pharmacology, as well as even birth control and maternal and infant care, and continued their farming work in the communes; this helped to make assistance to comrades readily available (Valentine, 2005). While the service was mediocre at best, both in terms of technique and available technology, the barefoot doctor program was effective in

providing healthcare services to the rural people in a timely manner and an affordable, if not low, cost to both the state and the individual (Zhang and Unschuld, 2008). Despite critiques, such as amateur doctors risking their own health and oftentimes becoming infected by diseases they were treating, residents seem to have an overall positive memory of the barefoot doctors who provided equitable medical services, especially once healthcare crises became more rampant after the decline of the system in the 80s due to the economic reform (Zhang and Unschuld, 2008).

This economic reform and liberalization resulted in a substantial shrinkage of the country's national health coverage, which dropped below 10% amongst the rural populace. This decline also extended towards the cities between the late 1970's to mid-1980's, where locals often found themselves struggling to access medical care, as medical insurance for urban residents halted coverage for the dependants of salaried employees. Prior to the reform, employees within the public sector and staff in state-owned factories benefited from public healthcare services, such as free medical coverage, which extended to approximately 200 million citizens; however, this eventually became unaffordable to the government. As such, the government scaled back on its financial support for public hospitals, reducing coverage to approximately 3% to 8% of a hospital's total annual income, which resulted in hospitals having to determine the fees for medical care sought by patients; today, this means that a physician's income is largely dependent on their earnings from patients (Qiu, 2012).

2.3.1 Healthcare Access

At present, the Chinese health insurance system is comprised of basic health insurance and commercial health insurance. Basic health insurance is run by the central government, containing three schemes or tiers that are based on Hukou status, while commercial health insurance acts as a complement to basic health insurance (Fang *et al.*, 2012). Currently, China has three tiers of

healthcare coverage: The Urban Employee Basic Medical Insurance (UEBMI) tier for employed urban residents, the Urban Resident Basic Medical Insurance (URBMI) for urban residents generally, as well as the New Cooperative Medical Scheme (NCMS) for residents in rural areas (Qiu *et al.*, 2012).

Following the collapse of China's nearly universal healthcare system which coincided with decentralization and market liberalization, China's two health insurance schemes, known as the Government Insurance Scheme (GIS) and the Labour Insurance Scheme (LIS) disintegrated due to the fiscal crisis that took place within the healthcare system. As a result of the financial burden that the Chinese government faced in an effort to maintain centralized healthcare, the country embarked on a pilot experiment for the creation of Medical Savings Accounts (MSAs) in 1994, which further extended to the creation of a health insurance scheme designed for urban residents known as Urban Employee Basic Medical Insurance (UEBMI). The pilot programs for UEBMI began in Shaanxi Province in 1999. This scheme targeted urban residents, including any dependents of workers in the urban sector, and enrolment is mandatory (Qiu *et al.*, 2012).

In addition to the UEBMI, the government launched Urban Resident Basic Medical Insurance (URBMI) in 2007, which was designed to lessen the financial burden that urban residents who are either unemployed or employed within the informal sector, including children and the elderly (Pan *et al.*, 2016). URBMI is managed and distributed accordingly throughout the 31 regions across China's mainland, and is regulated at the city level. As a result of this, eligible consumers can only decide if they will enroll, but not how much they will have to pay according to Chen & Yuan (2012: 659). Furthermore, Liu and Zhong (2014) argue that while URBMI is intended to provide what the government considers affordable healthcare to what could be considered as vulnerable groups (unemployed, dependents, workers in the informal sector),

URBMI was mainly intended to issue reimbursements for catastrophic, inpatient circumstances, and less so for general outpatient care.

China's post-reform period resulted in a disintegration of the once strong healthcare system enforced during the pre-reform period, the Cooperative Medical System, as previously mentioned. During the reform and post reform periods, while urban residents were provided with insurance either in the form of GIS or the LIS, the rural poor struggled to pay their medical bills, deciding to forego medical treatment as a result. This inevitably led in inflated rates of disease and mortality. Implemented by the Chinese government in 2003, the New Cooperative Medical System (NCMS) was created to address this issue (Adrian *et al.*, 2012: 15). The NCMS is afforded by the joint contributions of both the central and local governments, and is also funded by individual households (Ling *et al.*, 2011:12). One of its primary functions is to prevent rural households from encountering poverty as a result of expensive health costs (Liang *et al.*, 2012), since debt related to medical expenses can cripple rural households, preventing them from escaping poverty (Qiu *et al.*, 2011).

NCMS enrolment is voluntary, and is funded in thirds: central government contributions (one-third), the local government contributions (one third), and individuals insured under the NCMS (one-third). According to Qiu *et al.* (2011), at the time of their sampling in 2006, individual annual contributions from the central government amounted to approximately RMB20 (Chinese yuan) per person in the central government, RMB15-20 per person from the local governments, and RMB10-15 from each individual themselves; however, by 2015, the costs jumped to RMB60, RMB60, and RMB30 for each respective contributor. The principal objective of the NCMS is to minimize the financial impacts that disease can have on rural residents, especially farmers, and to protect them from impoverishment as a result of diseases that might befall them (Ling *et al.*, 2011:

12). The plan was designed to provide people in isolated areas of the country with affordable, professional care. However, while the plan does make basic and more localized care more reasonably priced for rural residents, it does little to absorb the impact of the costs associated with more complicated courses of treatment in city centres (Snyder, 2014), compared to urban recipients of the UEMBI category.

2.3.2 Who Benefits from Healthcare?

The previous section reviewed literature which outlined the details and the differences between the three insurance schemes in China's basic healthcare system, and their progression. However, Carine Milcent (2010) argues that this expansion of healthcare is fundamentally inequitable, as a result of the collapse of the country's public healthcare system.

Zeng *et al.* (2015), in their case study of medical institutions on Guangzhou, remind us of the Hukou system's impact on the lives of rural workers who migrate to urban areas for an improved quality life and employment opportunities, specifically that the transfer of Hukou from rural to urban areas is made difficult by the system, and that as a result, migrants face considerable disadvantages when trying to obtain "appropriate and timely healthcare." As an extension of this point, research conducted by Fan *et al.* (2013) supports the main argument of this research paper, which is that due to policies implemented by the government, health insurance, and therefore access to healthcare and adequate treatment, is ultimately better for urban residents than for migrants, who face considerable barriers to acquiring permanent Hukou status as an urban resident. The authors elaborate on this point further by citing Hesketh *et al.* (2008), who reports that only 19% of the migrants in their research sample had health insurance (most likely covered under the UEBMI scheme), compared to 68% of their urban resident counterparts. Mou *et al.* (2009) also found that while disease patterns amongst residents were similar regardless of whether they had

insurance, those with insurance were much more likely to seek medical attention for symptoms suggestive of serious and/or communicable diseases.

To better illustrate the above-mentioned point, studies such as those conducted by Shaokang *et al.*, 2002 and Feng *et al.*, 2005 describe reduced access to healthcare, and as a result, inferior health-seeking practices by migrants, as being very much linked to mobility, according to Hong *et al.* 2006, and Li *et al.* 2006. In studies conducted by Mou *et al.*, 2009 and Peng *et al.*, 2010, case studies conducted in Shenzhen and Beijing respectively, only approximately one third of the migrants who had reported being sick within the last two weeks actively sought medical care, while the rest resorted to self-medicating, or foregoing treatment altogether. Furthermore, two disease-focused studies on Tuberculosis treatment using Chongqing as a case study discovered that 68% of rural-to-urban migrants that eventually presented with symptoms of TB often forewent treatment for more than 2 weeks, while 54% of local urban residents sought treatment (Long *et al.*, 2008; Wang *et al.*, 2008). Hong *et al.*, 2006 explored the reasons behind not seeking or postponing seeking medical attention, and discovered that migrants identify a lack of insurance as well as the high cost of services coupled with low income as deterrents for seeking care. When compared to their urban counterparts, the high cost of services was reported by 15% of migrants as being a barrier to their pursuing treatment, while only 8% of urban residents identify with the same barrier (Hesketh *et al.*, 2008).

While the Hukou system has reformed throughout its history as described in 2.1.2, transferring Hukou from a rural to urban one is challenging as described by Huafeng Zhang (2010) in a paper on the Hukou system's constraints on migrant workers' job mobility. This more often than not leads to migrants relying on informal information networks in order to find jobs in the city rather than going through the hurdles of applying for urban Hukou, according Zhang. As such,

migrants are at a disadvantage for accessing adequate healthcare since they would not qualify for the same rates as those in the UEMBI or URBMI insurance schemes, meaning higher costs, and further disadvantage, which is why the Hukou system is a problem for equal healthcare access throughout the country.

2.4 Theoretical Applications

This section will provide an understanding of the selected theoretical framework by connecting it to the rest of the literature, and will enable us to understand why the inequality of healthcare accessibility for rural-to-urban migrants is a problem, why it blocks their *right to the city*, and why it therefore impedes spatial justice. A theoretical application is imperative to understanding both the research objectives and the findings. Without a theoretical component, the research would merely consist of facts lacking in interpretation and meaning, and would have a minimal contribution to the growing body of literature in this area. To begin, I will briefly outline the scope of Critical Urban Theory as the overarching theory of the research, followed by a discussion of the concept of spatial justice for migrants and their *right to the city*. Finally, the tenets of Confucianism will be explored in order to frame both the literature and theoretical applications in a Chinese context.

2.4.1 Critical Urban Theory

Critical urban theory evolved out of the writings of radical urban scholars during the post-1968 period, such as the writings from Henri Lefebvre, David Harvey, Manuel Castells, Peter Marcuse, and others who were inspired by them (Brenner, 2009). In particular, critical urban theory

“insists that another, more democratic socially just and sustainable form of urbanization is possible, even if such possibilities are currently being suppressed through dominant institutional arrangements, practices, and ideologies. In short, critical urban theory involves

the critique of ideology *and* the critique of power, inequality, injustice and exploitation, at once within and among cities” (Brenner, 2012: 198).

Critical Urban Theory is classified under the umbrella of critical urban studies. According to Brenner *et al.* (2009: 177-178), critical urban theory attempts to make sense of the ways in which, “under capitalism, cities operate as strategic sites for commodification processes,” and is interested in understanding the (a) connection between capitalism and urbanization processes; (b) the changing balance of social forces, power relations, sociospatial inequalities and political institutional arrangements; (c) exposing marginalizations, exclusions and injustices within existing urban configurations; (d) exposing contradictions, crisis tendencies and lines of potential or actual conflict in contemporary cities, and on this basis is interested in (e) exploring and politicizing the possibility of a free and sustainable urban life. Fundamentally, the function of critical urban theory is to expose the dynamics of capitalism and marginalization in the context of the city (Brenner *et al.*, 2009: 179), which is the only place where capitalism can dominate, and this dynamic “produces a continual conflict between profit-making and social motives that, instead of destroy urban areas, perpetuates them through ‘implosion-explosion’” (Weiler, 2015: 7).

2.4.2 Understanding the Right to the City & Spatial Justice

While Critical Urban Theory explores the dynamics of capitalism and marginalization, the theory of the *right to the city* is closely tied to Critical Urban Theory because it is concerned with the contribution and the rights of city participants, and how both their contribution and their rights in the context of urban expansion are challenged by capitalism and ultimately the state. The *right to the city* was conceived by sociologist and philosopher Henri Lefebvre. Having its roots embedded in Marxism, the theory falls under the umbrella of critical urban theory. As a neo-

Marxist, Lefebvre saw urban spaces as embodiments of capital formation, and argued that all residents of the city have a right to partake in the decision-making process for the development of that urban space (Weiler, 2015). Since Lefebvre's conception of the *right to the city* is both complex and fluid, there are various interpretations of what exactly constitutes a *right*. However, for our purposes, the paper will focus on the *right to the city* as the arena in which decision-making takes place, reorienting this decision-making away from the state and instead towards a production of urban space. What this means specifically is that "instead of democratic deliberation being limited to just state decisions, Lefebvre imagines it to apply to *all* decisions that contribute to the production of urban space, and stresses the need to restructure the power dynamics that underlie this production, fundamentally minimizing control by the state and capitalism, and maximizing it for the people" (Purcell, 2002: 101-102).

For Lefebvre, the *right to the city* is in large part about the production of urban space. He is concerned with the production of urban space since the conversation and planification of this urban space takes place between and within the confines of the state and capitalism. According to Lefebvre (1991), space consists of 'perceived space,' 'conceived space,' and 'lived space.' Purcell states that 'perceived space' refers to the relatively objective, 'concrete space' people interact with, while 'conceived space' means the mental constructions or imaginations of space, and lived space describes the individual's actual experience with both their perceived and conceived space in their daily life (2002: 102). In the context of *the right to the city*, these constructs of space are important to the individual's capacity to partake in the production of urban space, and are fundamental to the creation and sustainability of spatial justice.

According to Soja (2010: 62), spatial justice is defined as "an intentional and focused emphasis on the spatial or geographical aspects of justice and injustice." At its root, the concept

of spatial justice is concerned with how social inequalities are brought into the spatial dynamics of urban areas, especially, and for our purposes, the ability to participate and contribute freely and fairly to urban life. Stemming from this, the notion of spatial justice is a reaction to the diminished capacity for residents to control governance and decision-making (Weiler, 2015). The concepts of spatial justice and *right to the city* both lend themselves to one another if we are concerned with the rural-to-urban migrants' free and equal participation in the creation of a sustainable urban life and future, especially where equal access to social benefits, such as healthcare, is concerned.

2.4.3 Confucianism

In order to properly understand and apply Western theories, such as those that fall under the umbrella of critical urban theory, to the context of the Chinese Hukou system and urbanization, it is important to consider the literature that link the two dimensions together. A brief outline of Chinese theory, specifically Confucianism, is beneficial for the purposes of understanding the application of the *right to the city* and spatial justice to the Chinese context as part of the conceptual framework and methodology.

Eradicated during the Maoist era, yet resurfacing thereafter (Lu, 2014), Confucianism is a system of philosophical and socio-political teachings, which evolved out of the teachings of the Chinese philosopher, Confucius. The older Confucian principles as promoted by Han Yu⁶ articulated that Confucianism offers a high moral standard to those that follow the doctrines closely, and emphasized that moral and sage-like people who follow this doctrine can change society (Lu, 2014). However, proponents of New Confucianism articulate that electoral democracy is the best alternative to traditional concentrations of power, and focuses on how the state can

⁶ Han Yu was a renowned essayist, philosopher, politician and poet who lived between the years 768-824 during the Tang Dynasty in China, and was one of the “Eight Great Prose Masters” of both the Tang and Song dynasties.

better represent the general will (Weiler, 2015: 16). According to Chen (2012), proponents of the New School argue that Confucianism and Western liberalism should be combined to offer a more relevant guide in modern China. However, according Huntington (1984), some argue that Confucian philosophy does not jive with the democratic perspective, while others argue the opposite, which is that Confucian doctrine can help promote liberal democracy (Fukayama 1995).

According to Roy Tseng (2016), since the period of Isaiah Berlin's "Two Concepts of Liberty" (1958) and Chang Fo-ch'üan's *Tzu-yu yü jen-ch'üan* (Freedom and Human Rights) (1954), the notion that Confucianism and liberalism were in deep conflict with one another had spread. Tseng (2016) states that this was due to Confucianism's disassociation with a holistic conception of freedom and individualism as a result. However, if one reads further into Fukayama's article on Confucianism and democracy (1995), it can be observed that Fukayama makes an interesting argument regarding Confucianism's compatibility with democracy. Fukayama states that Confucianism could be categorized into two types, which were "political Confucianism" and "Confucian personal ethic." Fukayama argues that while political Confucianism was more so tied to the imperial system and its supporting bureaucracy of gentlemen-scholars that Confucianism "does not legitimate deference to authority of an all powerful state that leaves no scope for the development of an independent civil society" (Fukayama, 2015: 28). Extrapolating from Fukayama's point on political Confucianism, Bell (2010) identifies the marriage between Confucianism and liberal democracy when exploring the *Analelects* of Confusion, which regards exemplary persons as "seeking out harmony, not conformity" (Bell, 2010). This doctrine suggests that harmony is akin to a democratic and therefore liberal perspective, one that is naturally in pursuit of spatial justice, one that does not merely relinquish control to the state. While there are differing perspectives on the relationship between

Confucianism and liberal democracy, the relationship (Bell, 2010) provides a solid base to apply Lefebvre's theory of *right to the city*, combined with the theory on spatial justice, to the Chinese context, especially where it pertains to rural-to-urban migrants and their *right to the city*.

The selected theories and the corresponding literature are fundamental in understanding the basis of the inequalities that persist concerning healthcare accessibility with the Hukou system still in place. The application of the *right to the city* combined with spatial justice places emphasis on the inequalities and the resulting consequences examined earlier on in the literature review. The application of Chinese thought, specifically Confucianism, in conjunction with the other two theoretical linkages, helps us to understand the application of Western theory to a Chinese context, and helps to articulate and emphasize the importance of liberal democracy in the context of Chinese urbanization.

While the exploration of the literature provided a more in-depth review of both the context and the problem, the research is incomplete without a statement of the research question and the application of a conceptual model to guide the following sections and unify all themes and concepts. The literature review assisted in identifying the various themes in the research, which are fundamental to a holistic understanding of the topic. However, this would also prove challenging without a clearly-stated research question, and a conceptual model. Therefore, the following chapter states the research question, and outlines the conceptual model.

Chapter 3: Research Framework & Methodology

The last chapter provided a review of the literature gathered for completing the research objectives. The literature explored the history of the Hukou system, examined the evolution of urbanization and the current urban agenda in China with the New-Type Urbanization Plan, as well as the structure of the country's healthcare system. These chapters were then unified with a review of literature for the application of relevant theory. This chapter will identify the research framework and the methods used. The chapter will begin by stating the research questions to be explored, and will then apply these questions to a conceptual framework. This chapter will be instrumental in identifying the framing to be used to realize the research objectives.

3.1 Research Framework

3.1.1 Research Questions

Throughout the course of the literature review, it has been identified that the healthcare system in China is in need of further reform and evolution for the equal access of healthcare for everyone, regardless of Hukou. Moreover, for rural migrants in China's cities, access to equal and affordable quality healthcare is a problem. This is for several reasons, as identified by the review of the literature, predominantly a result of the legacy of the Hukou system prior to reform, which was designed to create and maintain a spatial hierarchy between the rural countryside and the industrial centres, as previously discussed. As an extension of this, the structure of China's healthcare system perpetuates a divide of a less visible spatial hierarchy, now that rural migrants have moved into cities, and are living and working in them. Migrants frequently forgo medical attention due to the high cost of healthcare outside of their bracket, which is based on their official

Hukou status. This results in their marginalization, and takes away what Henri Lefebvre refers to as their *right to the city*. Owing to the literature review, this research paper will further explore the issues faced by rural migrants regarding healthcare access. The research will sample different case study incidences pertaining to tuberculosis treatment accessibility for migrants in urban centres to comprise a larger case study. Tuberculosis is a highly effective example which strongly elucidates the disparities between migrants and urban locals when seeking treatment; however, the research also acknowledges that tuberculosis is just one of many other diseases, communicable or otherwise, that could serve the same function for the research objectives. Tuberculosis was also selected as the main case-study topic due to its presence in various parts of the country, and also because general literature on the inequalities of healthcare access and Hukou status in one specific location proved to be sparse. The paper will argue that the structure of China's healthcare impedes equal accessibility to adequate and affordable treatment of the disease. To do this, the research will answer the following question: *Does China's Hukou system implicate equal healthcare accessibility for rural-to-urban migrants, and inevitably their right to the city and spatial justice?*

In responding to this question, the following three sub-questions will help to structure an analysis and discussion for the purposes of the response:

- 1) How does the Hukou system impact rural-to-urban migrant healthcare access despite reform over the last several years?
- 2) How does migrant healthcare access compare to those with urban Hukou?
- 3) How does spatial inequality created by the Hukou system obstruct rural-to-urban migrants' *right to the city*?

The discussion will enable for the answering of the above-listed questions, particularly through a focus on the relationship between various levels of government, specifically the central, local, and

provincial governments, when implementing policies, as well as through a focus on the impact that this has on migrant healthcare access in urban centres. To elucidate this dynamic, I have elected to use a case study of a disease rather than a specific location. The case study will look at tuberculosis treatment for rural migrants in both their Hukou context (receiving insurance coverage under the NCMS) as well as their urban context. Reasoning for using this approach as a case study will be justified below in the section outlining the methodological approach.

3.1.2 Conceptual Model

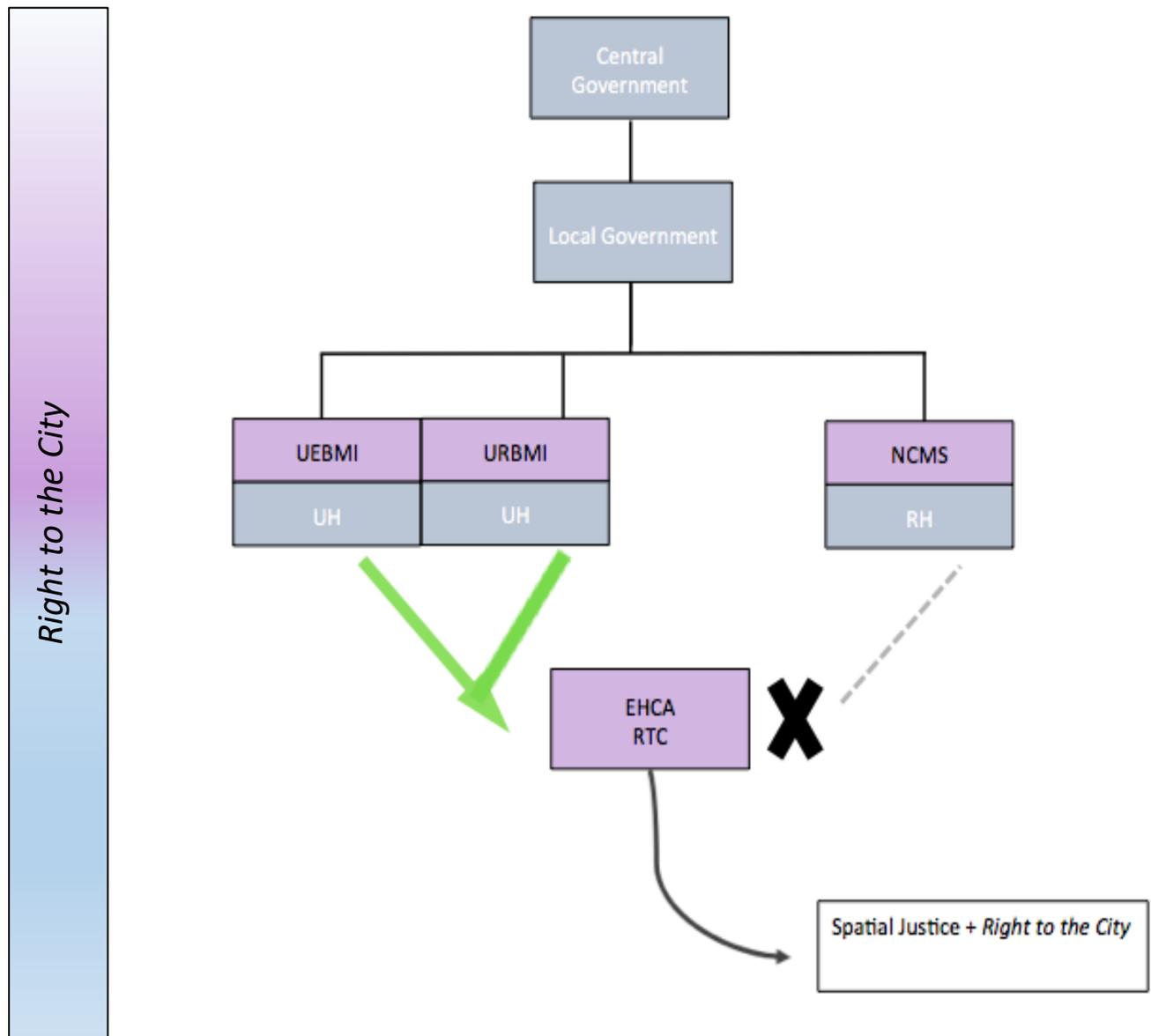
The conceptual model (Figure 3.1.2) presented below is supported by the literature review conducted in the previous chapters of this research paper, and is crucial in answering the research questions outlined above. The conceptual model based upon critical urban theory, specifically that of Lefebvre's *right to the city* (Lefebvre, 1968), in conjunction with the concept of spatial justice (Marcuse, 2009). The application of both of these theories will prove beneficial in understanding the consequences of the Hukou system on rural-to-urban migrants' contribution to an equal and sustainable urban future. Lefebvre's approach to the *right to the city* is entrenched in the notion of equality, that everyone is equal regardless of status and position within the societal landscape. The function of this concept is both to, a) on its own, demonstrate that regardless of the size of physical space, everyone has a right to live freely and equally and with reasonable enjoyment in a shared and, therefore, public space, and, as an extension of this point, b) to demonstrate that urban space is not equally shared with migrants, and that migrants do not have equal access to adequate healthcare and medical treatment, as a result.

The proposed case study in this research paper is tuberculosis treatment for rural residents and migrants. According to the argument of critical urban theory, the fact that rural migrants encounter barriers to adequate healthcare access as a result of the Hukou system creates a context

of inequality for rural migrants in urban centres. This will be visually represented in the conceptual framework, which will also demonstrate the unidirectional relationship between the central and local governments. The conceptual model will also depict the administration of healthcare based on the identified insurance brackets discussed earlier on in the chapter.

Owing to the application of the following conceptual framework, we can move forward to the analysis and discussion of the literature. This conceptual model enables us to better understand the arguments presented both in the introduction and the analysis and discussion portions of this research paper, which will enable for an adequate debate on the topic, as well as assist in drawing conclusions.

Figure 3.1.2 – Conceptual Model



Legend	
EHA	Equal Healthcare Access
NCMS	New Cooperative Medical Scheme
RTC	Right to the City
UEBMI	Urban Employee Basic Medical Insurance
URBMI	Urban Resident Basic Medical Insurance

3.1.3 Conceptual Model – Explanation

The Figure 3.1.2 represents the conceptual framework. Principally, this framework is rooted in the philosophical ideology of Henri Lefebvre's *right to the city*, and also demonstrates the conception of spatial justice rooted in Critical Urban Theory as discussed in Chapters 2.4.1 and 2.4.2. When considering this conceptual framework, it is important to examine it within the context of the research question, especially the three sub-questions identified in the section dedicated to stating the research questions to be answered. The aim of the conceptual model is to make the identification of the problem simple. The main question is whether China's Hukou system implicates equal healthcare accessibility for rural migrants, and inevitably their *right to the city*.

The conceptual model is structured vertically to demonstrate a hierarchical representation, and then horizontally to demonstrate the spatial inequality between urban locals and rural migrants. We see the central government as the overarching authority, followed by the local government, representative of the administration of healthcare. Below, I have chosen to place the three tiers of health insurance. They are not arranged vertically to demonstrate hierarchy, but rather horizontally, side-by-side. We can observe, however, that while those who are subject to enrollment in the urban health insurance schemes are placed close together, those with rural Hukou, and thus enrolment in the NCMS, are positioned further to the right of the model, representing their distance from the urban schemes. This can be interpreted according to the first sub-question, which is concerned with how Hukou distinctions can impact healthcare accessibility. The smooth, green arrow stemming from both the Urban Resident Basic Medical Insurance and the Urban Employee Basic Medical Insurance pointing towards the block categorized as Equal Healthcare Access represents difficulty accessing social benefits, specifically healthcare access in our case, and therefore a more

facilitated access to the city and more space to live a higher quality of life in the city; the second sub-question can be referred to when considering this, because this aspect of the model depicts a clear disparity between migrant healthcare accessibility when compared to their urban counterparts. Contrarily, the light-grey tracks followed by the black “X” is an explicit suggestion that rural migrants do not have the same level of accessibility within urban life, and therefore have limited space to benefit compared to urban residents. For them, healthcare access is unequal, limiting their quality of life. This image is representative of the third sub-question, which is concerned with the implications of the spatial inequality created by the Hukou system, and how it infringes on migrant rights to the city. It is also important to consider that the spacing of each category reinforces the notion of spatial justice.

3.2 Research Methods

This section begins with an explanation of the case selection and continues with a description of the methods used to analyze the case. The section of tuberculosis treatment access for migrants in urbanized areas as the chosen case study for demonstrating the issues pertaining to healthcare access for migrants will be explained. After justifying the case selection, I will then describe the methodology used to conduct my research and analysis.

3.2.1 Site & Case Study Selection

The selection of China as the country focus for this research paper is based on an interest in localized passport systems. My own experience living in the city of Xi’an, Shaanxi Province as a foreigner inspired my interest in the Hukou system, especially upon learning that migrant workers were often employed in a very different sector than residents with urban Hukou because

they themselves could not obtain local Hukou. While the implications of the Hukou system impact rural migrants throughout the country, for the purposes of this research topic, the focus of which is the impact of Hukou on healthcare access for rural migrants, I have chosen tuberculosis as my selected case study. Specifically, I have chosen to address the tendencies of rural migrants in urban centres when seeking treatment for tuberculosis, as well as how this impacts their health outcomes, as well as how it impacts the public health. While China has a history of a tuberculosis epidemic, and while the prevalence of smear-positive tuberculosis had decreased over a span of 20 years, tuberculosis is an interesting example of a disease that spreads due to inconspicuous symptoms, slow seeking of treatment, as well as limited treatment options for rural migrants (Wang *et al*, 2014), and is therefore an apt case study to demonstrate the inequalities for treatment opportunities between locals and migrants.

Geographically speaking, the region of study in this research paper will be broadened to the various locations across the country, focusing on urban centres; however, it should be noted that I have decided to refrain from choosing a specific location within the country, and will rather be focusing on various urban centres to demonstrate my argument. This is because urbanization in China is extensive, and examples for my selected case study have been pulled from various regions and urban centres; the prime focus of the case study is tuberculosis within the country.

3.2.2 Methods

The methods used for executing this research paper consist largely of qualitative content analysis. Schreier (2012) states that qualitative content analysis is “one of the several qualitative methods currently available for analyzing data and interpreting its meaning,” and as a research method, “represents a systematic and objective means of describing and quantifying phenomena” (Downe-Wambolt, 1992: 314). According to Cavanagh (1997), Elo & Kyngäs (2008), and Hsieh

& Shannon (2005), a prerequisite for quality content analysis is that the data involved can be reduced to concepts that help to describe the phenomenon. It does this by creating “categories, concepts, a model, conceptual system, or conceptual map” (Elo & Kyngäa, 2008; Hsieh & Shannon, 2005), such as the conceptual model depicted above. This method of research has been very helpful in enabling me to compare the general experience of migrants and urban residents when comparing the level of accessibility of the country’s healthcare system for both groups. The research groups together the following concepts based on content analysis of the literature: Hukou; urbanization; local; rural; migrant; government; social benefits equality; marginalization; healthcare access; justice; space. Content analysis has also made the relationship between important concepts such as Hukou and the accessibility of social benefits, specifically healthcare, more visible. Manual content analysis was performed using a manual colour-coding system to identify and establish common themes, which eventually helped to formulate the structure of the research and the paper.

Chapter 4: Data Collection, Results, and Discussion

The preceding chapters focused on building the context and methodologies in support of this chapter, which will consist primarily of the interpretation of quantitative data, the research analysis, and finally a discussion and review of the findings. To provide a clear representation of the information, Chapter 4.1, will focus on the collection of data based on mixed case studies looking at tuberculosis treatment and the variables involved. Based on the collection of this information, the section will also provide an analysis of the treatment-seeking tendencies, treatment costs, as well as treatment quality for migrants with tuberculosis, and how the structure of China's healthcare system has contributed to the context of unequal healthcare accessibility for rural migrants. Lastly, Chapter 4.3 aims to discuss the information provided in both the presentation and the analysis of data, within the scope of the paper's general argument, and aims to demonstrate that the preservation of the Hukou system, has resulted in an unequal distribution of healthcare. Stemming from this, I will further demonstrate that this unequal distribution of healthcare preserves the spatial hierarchy established prior to reform, blocking migrants' equal *right to the city*, as articulated by Henri Lefebvre.

4.1 Data: Collection & Results

4.1.1 Tuberculosis & Migration: Overview

Tuberculosis (TB) is a disease that has been present for centuries, but is defined as a major global health concern by the WHO, causing health issues in millions of people each year (WHO, 2016). The WHO (2016) also estimates that in 2015, there were 1.4 million deaths as a result of

TB, and an additional 0.4 million deaths for those who were already immune-compromised by HIV.

With the second largest TB burden in the world, and with the prevalence of active TB cases in rural areas double that of urban areas, growing population mobility in China has become one of the major challenges in TB management, specifically with a total of more than 200 million people migrating from rural to more abundant urban areas in recent years (Wei *et al.*, 2012). Throughout the last thirty years, consequential to the beginning of economic reform as discussed, China has experienced an increase in the floating population, those who migrate to urban centres to make a better living than they would otherwise in the country-side (Tang & Squire, 2005). The International Organization for Migration (2015) states that approximately 269 million internal migrants in China have made their way from rural to urbanized areas in 2015 hoping to find jobs with good pay and potential benefits.

According to Yi *et al.* (2011), drug-resistant *Mycobacterium tuberculosis* (MTB/MDR-TB) was a mutation of tuberculosis which was once confined mainly to hospitals, but has now become a widespread communicable disease that at present stands to sabotage the modern-day efforts of TB control. The authors state that drug-resistance is associated with several factors, which include poor compliance to TB treatment plans, and that initial transmission of MDR-TB is responsible for perpetuating the MDR-TB epidemic. Yi *et al.* (2011) also emphasize that patients diagnosed with MDR-TB do not respond well to “conventional first-line therapy,” and are expensive to treat, and usually remain contagious for long periods of time. Currently, TB is managed using the DOTS (Directly-Observed Treatment) program as the WHO recommended regimen to treat patients, which prescribes short-course chemotherapy, and facilitates the administration and prescription renewal for patients in the program (Yang *et al.*, 2012).

However, despite the DOTS program, the movement of migrants from western to eastern China has significant implications for controlling the spread of TB. The pervasiveness of communicable tuberculosis in the western provinces of China was between 1.7 and 2.4 times larger than provinces in the east, suggesting that movement from western and central China may be responsible for an increase in the frequency of TB in eastern provinces and cities (Li *et al.*, 2012) as demonstrated above by the influx of their migrant population. When considering migration to eastern areas, it is necessary to consider that the floating population is not very knowledgeable about the intricacies of the contraction and spread of communicable diseases such as TB (Wang *et al.*, 2011). The data is based on the selection of different case studies, and aims to demonstrate that rural migrants are at a disadvantage compared to residents in urbanized areas when it comes to healthcare access for the diagnosis and treatment of tuberculosis. While there are several factors to consider, the research has identified three key factors in determining the significance and experience of TB treatment for migrants according to the selected case studies. The three key factors are as follows:

- 1) Initial health-seeking (IHS) patterns of migrants (Wang *et al.*, 2008; Li *et al.*, 2012)
- 2) Ability to recognize TB symptoms (Qian *et al.*, 2008; Strand *et al.*, 2006/2007)
- 3) Cost as a deterrent factor for treatment (Long *et al.*, 2011; Chan *et al.*, 2015; Fitzpatrick *et al.*, 2011)

These factors were selected because they will be unique in helping to pinpoint the significance and impact, not only of the disease, but also the disparities present within the country's healthcare system, which is structured around Hukou. They will also be useful in demonstrating whether this impact has further consequences on an individual's *right to the city* and spatial justice when comparing the treatment experience of urban residents to rural-to-urban migrants in eastern China.

The data have been extracted from different case-study publications, including Li *et al.* (2012), Wang *et al.* (2008), Qian *et al.* (2012), and Lambert & Van der Suyft (2005).

4.1.2 Characteristics of New TB Migrants

When considering our model of tuberculosis as an example to demonstrate healthcare accessibility in China, it is important to consider the characteristics of those most commonly carrying the disease. The individual's social demographics are necessary for understanding how they may have contracted the disease based on factors such as age, sex, housing situation, distance from the appropriate facility, as well as whether they have health insurance. Table 4.1.2 is from a study conducted by Li *et al.* (2012), which represents several of the characteristics of migrants with new incidences of PTB. This population sample was pulled from Shanghai, Guangdong and Jiangsu, China, in 2008. The table provides a contextual basis in terms of some of the variables that are important when considering TB suspects/patients, not only for this study, but could also be used as a scale for other populations in eastern China that are subjects of a similar study. Here, we see that the majority of the population in the sample is male, and the population majority also consists of migrant workers, which can be interpreted as males being the breadwinners of the family. We can also observe that the ratio of household expenditure to income is also 0.75, which demonstrates that this is statistically significant to being diagnosed with TB. We can interpret this as meaning that those who have TB and are undergoing treatment are spending a large majority of their household income on staying on course with treatment. We can also observe that the majority of the population is also experiencing the symptoms of TB, specifically cough, bloody phlegm, as well as chest pain and fever. What is especially significant is that 93.5% of this population does not have medical insurance within their city, and we can argue that it most likely indicates that

they are currently covered under the New Medical Cooperative Scheme as migrants, especially since 60% of this population is considered to be comprised of migrant workers.

Table 4.1.2 – Social demographics of migrants with new incidences of PTB based on a population sample pulled from Shanghai, Guangdong and Jiangsu, China, in 2008

Variables	No.	%
Gender		
Male	206	64
Female	117	36
Age (years)	30 (20,24)	
Education		
Elementary school or less	69	21
Junior high school	149	46
Senior high school	105	33
Marital status		
Single	106	33
Married	207	64
Occupation		
Migrant workers	194	60
Unemployment	65	20
Average working hours per day	8 (6,10)	
Average monthly working days	25 (20,28)	
Type of living quarters		
Rental housing	237	73
Dormitory	49	15
Years of living in accomodation place		
≤ 1	54	17
> 1	269	83
Main source of family income		
Own and other family member's income	158	49
Own income	108	33
Only other family member's income	57	18
The ratio of household expensidutre to income in 2007	0.75 (0.53-0.92)	
Symptoms before initial health-seeking		
Cough or expectoration	213	66
Hemoptysis or bloody sputum	68	21
Chest distress or chest pain	136	42
Fever	84	26
No medical insurance in city	302	94
Distance (kilometers) between residence and TB dispensary/hospital	15 (5,25)	
Duration (days) of initial health-seeking	10 (1,30)	

Source: Li *et al.* (2012)

4.1.3 Factor 1: Initial Health Seeking (IHS) Behaviour

Table 4.1.2 depicted what Li *et al.* (2012) have determined as variables for tuberculosis infection. The table demonstrated that a large majority of the population sampled in that case study both a) had symptoms of the disease, but b) took an average of 10 days before seeking treatment. Given that we have observed these variables, and that the severity of the symptoms indicated in the table did not prompt a sooner visit to a healthcare professional for treatment, it is valuable to look more closely at the variable of delay in going to seek treatment and its relationship to the amount of knowledge migrants have about the disease, which will be discussed in the following section on the ability to recognize TB symptoms. Table 4.1.3 represents the treatment-seeking tendencies of migrants, specifically treatment-seeking delay.

Table 4.1.3 – Rate of delay in seeking medical attention for symptoms in Shanghai, Guangdong, and Jiangsu, 2008.

	Migrants % (N)	Residents % (N)	Total % (N)
Non-delay	32.3 (74)	46.1 (357)	42.9 (431)
Delay	67.7 (155)	54.0 (419)	57.1 (574)
Total	100 (229)	100 (776)	100 (1005)

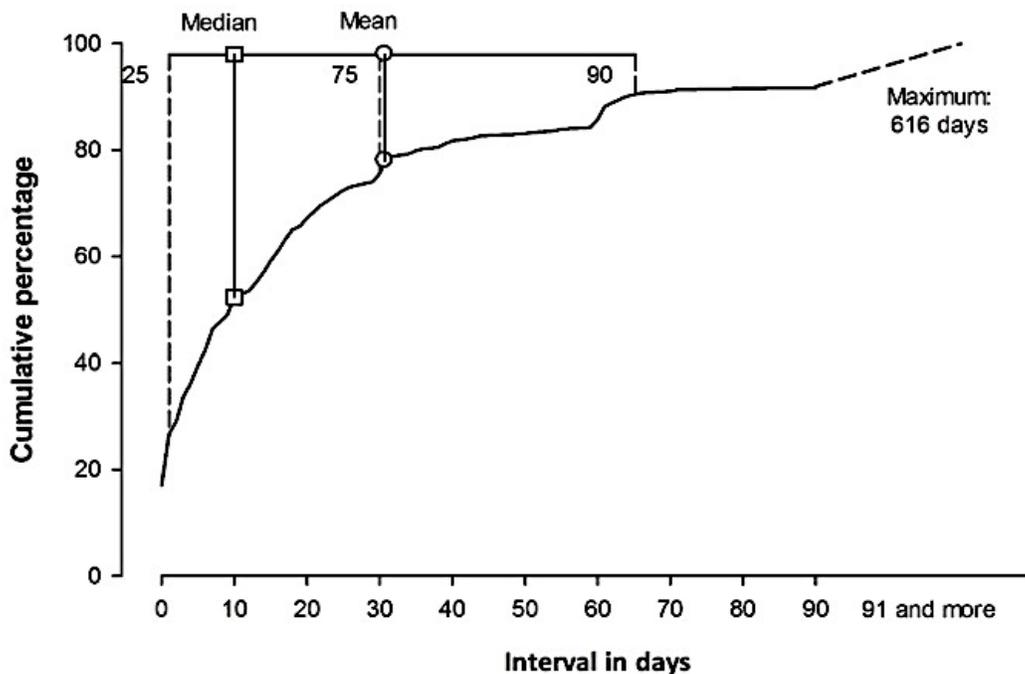
Source: Wang *et al.*, (2008)

The findings in this case study conducted by Wang *et al.* (2008) determined that the majority of TB cases are mainly discovered by what they refer to as “passive case finding,” meaning that those with symptoms suggestive of TB are typically identified when they decide to seek medical attention. They are then diagnosed after they are referred to a TB dispensary to have a smear conducted. The findings distinguish between migrants and residents in a two-county samples in Chongqing. If we observe the data, we notice that migrants delay seeking treatment more so than residents. The study determined that the median amount of time taken before seeking medical

attention was 18 days for residents, and 23 for migrants; 67.7% of migrants postponed seeking healthcare, while 54% of residents delayed. The case study findings also demonstrated that 40.2% of migrants delayed more than four weeks before receiving medical attention, compared to only 27.9% of urban residents.

The graph in Figure 4.1.3, based on another case-study conducted by Li *et al.* (2012), displays data that is complimentary to that shown above in Table 4.1.3., as we can observe the same phenomenon which measures Initial Health Seeking (IHS) behavior in migrant populations recruited from Shanghai, Guangdong, and Jiangsu.

Figure 4.1.3 – Cumulative interval in days between self-reported symptom onset and attending the first healthcare facility; cases amongst migrant population recruited in Shanghai, Guangdong, and Jiangsu, China in 2008.



Source: Li *et al.* (2012)

The population from each city consists of migrants newly infected with pulmonary tuberculosis (PTB). Charting IHS behavior amongst migrants in the study, we can see in the graph

that approximately slightly under 20% of the population has sought medical attention in the first few days of symptoms. The authors articulate that this proportion is consistent with two other studies conducted by Huang (2007) and Wang (2007) who say that migrants who encountered more serious symptoms, such as coughing up blood, went to see the doctor more quickly than those who had milder symptoms at the onset of the disease. This delay, followed by an alarming symptom as the prompt for IHS has a strong indication that migrants do not have adequate knowledge about the severity of the disease, as well as the spread of the disease, and therefore treatment.

4.1.4 Factor 2: Ability to Recognize TB Symptoms

In attempting to understand why migrants delay seeking medical attention when symptoms are evident, it is important to consider that they might not have sufficient knowledge of the disease to prompt their visit to a healthcare professional. For example, according to Lambert & Van der Suyft (2005), a majority of patients are unaware of some of the milder symptoms of TB, such as cough and sputum, or even that early detection and treatment can significantly improve their chances of a full recovery as shown in Li *et al*'s study (2012); this results in the logic to seek treatment once symptoms become more severe and therefore more concerning. Table 4.1.4 demonstrates the difference between migrant knowledge of tuberculosis when compared with urban resident knowledge of the disease. The table is based on a case-study conducted by Long *et al.* (2008), which demonstrates that knowledge and awareness of some of the facts associated with tuberculosis had a large influence on whether migrants sought medical attention.

Table 4.1.4 – TB knowledge of migrants versus residents in a first-round survey conducted in Chongqing, 2004.

		Migrants % (N)	Residents % (N)	P values
1. Have you heard of TB?	Yes	74.2 (170)	87.1 (676)	P > 0.05
	No	25.8 (59)	12.9 (100)	
2. Does TB have the symptoms of chronic cough?	Yes	32.3 (74)	45.1 (350)	P < 0.01
	No	67.7 (155)	54.9 (426)	
3. Does TB have the symptoms of hemoptysis?	Yes	36.7 (84)	64.4 (500)	P < 0.01
	No	63.3 (145)	29.1 (226)	
4. Is TB communicable	Yes	62.9 (144)	82.5 (640)	P < 0.01
	No	37.1 (85)	17.5 (136)	
5. Can TB be treated free?	Yes	38.0 (87)	53.2 (413)	P < 0.01
	No	62.0 (142)	46.8 (363)	
6. Have you heard of TB dispensary?	Yes	61.2 (93)	58.6 (309)	P < 0.05
	No	38.8	41.4 (218)	

Source: Li *et al.* (2012)

The survey conducted in this study determined that migrants had lower levels of awareness about the disease when compared to urban residents. While the majority of migrants have heard of TB (74.2%), more residents reported knowing about the disease. More residents also knew that chronic cough and hemoptysis (coughing of blood) were telling symptoms of the disease. Compared to their urban residents, migrants did not know that TB is communicable, as well as can be cured for free. The majority of migrants also did not know that TB dispensaries existed. The first question and the last question have *p* values of 0.05, which demonstrate a statistically significant response. We can interpret this as the first question regarding hearing about TB and the last question regarding knowledge of TB dispensaries being keys to controlling the spread of the disease; if one has heard of it, they will be more vigilant, and if one knows where to obtain medical attention, they will most likely go if needed. The key to bridging this gap is understanding why migrants delay seeking treatment.

4.1.5 Factor 3: Cost as a Deterrent Factor for Seeking Treatment

When trying to understand why migrants delay seeking treatment during the onset of TB symptoms, it is important to consider more than just their knowledge of the disease as the principal factor of delay in IHS. The expenses incurred when seeking treatment is also necessary to consider, as migrants do not have many financial resources; they migrate to urban centres in the hopes of securing a better financial future for themselves, after all. In a study conducted by Chan *et al.* (2015), the researchers analyzed the relationship between costs associated with treatment for TB and overall adherence versus deterrence for seeking and continuing treatment, the results of which we can find in Table 4.1.5. The case study conducted by Chan *et al.* (2015) shows the medical expenditures of TB patients, including OOP (out of pocket payment) for diagnosis and treatment. The study divides the costs for treatment between compliant and non-compliant TB patients. The majority of this sample population consists of rural residents, with a population of 736 rural residents out of 797 (total sample population). The costs are determined in China's RMB currency (*renminbi*). It can be observed that the costs are exceptionally high for out of pocket treatment (OOP), with costs being higher for those who do not comply with treatment, suggesting that the non-compliance results in higher costs due to re-injection of TB, which is expensive and even more difficult to treat as articulated by Yi *et al.*, (2011).

Table 4.1.5– Medical expenditure of compliant and non-compliant patients in a sample from Jiangsu Province, Hubei Province, and Shaanxi Province in 2013.

	Compliant		Non-compliant	
	Mean	Median [IQR]	Mean	Median [IQR]
Total costs on diagnosis and treatment	10146	5225 [2500-11638]	17597	8400 [3000-30000]
OOP payment for diagnosis and treatment	7154	4000 [2000-8000]	11164	4100 [2500-11000]
Transportation cost (including companion members)	251	114[32-280]	247	164[39-365]
Lodging and food costs (including companion members)	526	120[0-640]	881	265 [54-753]
Income reduction due to missed work days/hours (including companion members)	385	0 [0]	176	0 [0]
Dietary supplement costs	305	250 [1500-8000]	289	200 [200-500]
Sold	4093	2750 [1500-8000]	6000	6000[6000-6000]
Borrow	10586	5000[3000-15000]	12515	4000 [1500-20000]

Chan *et al.*, (2015)

The data also demonstrates the expenses related to seeking treatment for TB, which include transportation and food costs for the patient and any companions, as well as income reduction due to missed days of work. The study also noted qualitative findings, demonstrating that the inflated costs of examinations, tests and additional medications are substantial, with overuse of CT scans and chest X-rays (Chan *et al.*, 2015). Some of the responses that illustrate this best include:

“Within a month, I had two CT scans and a chest X-ray”

“The cost is high because of other checks (such as CT scans).”

“ . . . drugs are free, but the examination fees will cost more than 230 (RMB) a month”

“ . . . some drugs are free, but examination fees and other adjuvant fees are higher (than free drugs would have cost).”

A study by Long *et al.* (2011) compliments the above case study by Chan *et al.*, 2011. The study examined the ratio of household income to household expenditure on TB treatment. The authors acknowledge that following the explosion of TB rates in the 1990s, which they thought was a direct result of rural migration, the government implemented free treatment for the disease in the hopes of minimizing its spread, if not eradicating it completely. Despite this, however, healthcare providers have found ways of earning revenue from TB patients, with clear evidence that providers do things such as recommend a course of treatment beyond the drug course, request further investigation and more imaging tests and blood work. It should be acknowledged that each

of these services require payment since these additional services are not covered in the government's TB treatment policy. The study aimed to determine the cost of medical care for TB patients, the range of estimates for default, as well as a link between cost and staying on course for recovery based on data gathered from three other studies (Liu 2010, Meng 2004, and Zhang 2007). The authors observe that while there was not necessarily any obvious relationship between costs for treatment and the household income category, they did observe that the "average cost as a proportion of total household income increased in the low income groups," (Long *et al.*, 2011), demonstrating that cost is a large factor in determining compliance or default of treatment.

In another study carried out by Fitzpatrick *et al.* (2015), the researchers assessed cost-effectiveness of tuberculosis treatment in four areas of China: Chongqing municipality, Henan province, the Inner Mongolia Autonomous Region and Jiangsu province using a comprehensive programme to compare to the baseline program. In the comprehensive program, sputum samples were taken from patients who had presented with positive samples for PTB, and these patients were then enrolled in the program. The comprehensive study offers several differences to the baseline study, especially where it pertains to the component of cost. This program deviates from the baseline programme's fee-for-service method, and instead offers a standard package with a control on fees surpassing the package (any additional medical costs from standard treatment). Furthermore, based on the design, 90% of the fees in the standard package in the comprehensive program were refunded both by insurance schemes and the programme; in the baseline programme, reimbursement was only provided by the New Cooperative Medical Scheme, which was only 20-80% for services conducted for inpatients, and was 0-80% for outpatient services. This suggests that if additional costs are controlled for that migrants would not be taken advantage of.

Furthermore, in reviewing components to the factor of cost as a deterrent to seeking treatment, Wang *et al.*'s 2008 study determined a 95% confidence interval with a p value of 0.05 ($P > 0.05$) when measuring the significance of full and part-time employment (being employed generally); according to the study, those who were employed demonstrated a higher likelihood of delaying seeking medical attention compared to those who were retired, unemployed, or 'laid off.' More significantly, those that did not have health insurance were much more likely to delay than those with insurance; this was determined by a high confidence interval of 1.78-2.98, demonstrating a significant relationship between having health insurance and seeking treatment, which is ultimately a factor of cost.

4.2 Discussion & Interpretation

The previous section focused predominantly on the data presented in the tuberculosis case studies. The data was collected based on three main factors when considering the relationship between tuberculosis and rural migrants, which were the ability to recognize TB symptoms and one's overall general knowledge about the disease, initial health seeking (IHS) behaviour when obtaining treatment for the disease, as well as cost as a deterrence for seeking treatment. While the rest of the paper helped to build the context in preparation for the discussion, this section aims to demonstrate the overarching argument of the research conducted. The discussion will explore three main problems identified in the literature and the data, which will consist of 1) the legacy of the Hukou system and its purposes for the government, 2) economic decentralization and the structure of the healthcare system, and finally, 3) the impact of this structure on equal healthcare access and inevitably its impact on spatial justice and one's *right to the city*, which will be examined upon revisiting the conceptual framework. These problems will assist in answering the research question.

4.2.1 Problem 1: The Hukou System – Current Agenda?

In Chapter 2, we learned about the Hukou system and its initial function and practice for the Chinese government. We learned that it was used as part of the many techniques of social control by the Party (Cheng & Selden, 1994), designed to deter rural-to-urban migration (Kuang & Liu, 2012), and that this manipulation was a fundamental component to the achievement of the socialist planned economy for Maoist ideology. Ultimately, this system created a spatial hierarchy, where people living in the urbanizing industrial sectors were prioritized over those living in the countryside working to facilitate the growth of the urban sectors by means of providing for them.

The end of the Cultural Revolution precipitated by the country's reform and economic decentralization has resulted in a migration surge from the rural countryside to urban centres across the country. However, as we have observed, this migration does not mean that rural migrants become urban residents. The criteria for change in residency is conditional and very strict, and it is important to keep in mind that while the Hukou system has been relaxed due to economic reform and urbanization, that the system makes free and nonconsequential migration very challenging for rural migrants. While the Hukou system has relaxed from the more stringent policies of the pre-reform period, we could argue that if the Hukou system is now viewed merely as a population registration system to distinguish between rural and urban residents, that not too much has changed from its original purpose (Cai, 2011). The fundamental difference would be the function served by both groups, and it is no longer the case that rural residents serve the function of providing for urban residents in industrializing areas.

It is important to consider that without continued and substantial reformation of the Hukou system, social welfare benefits would not be independent of one's Hukou. So, what, then, is the current purpose of the Hukou system? Is it necessary, and if so, could it be modified to create a

more free and equal society for migrant integration rather than marginalization? Cai's (2011) research shows us that while the government has reformed Hukou, there are government motivations for its reform, rather than its removal. The first is a shortage of migrant workers in urban centres, which began in 2003, and became more severe during the financial crisis of 2010, which impacted enterprises' abilities to recruit workers, in which the government relaxed Hukou to stabilize the labour supply; the second is land-usage. Cai (2011: 43) determines that with

“strict control over arable land use, the only way that local governments can exploit land to boost urbanization is to reclaim plots of contracted arable land and house sites left behind by those who have migrated away, and use the quota of those plots elsewhere to balance the reclamation and exploitation of land.”

The Hukou system is never officially removed, but is *reformed* for the government to achieve its objectives. By reforming, but not completely removing the Hukou system, the government can both a) maintain the spatial hierarchy created during the pre-reform period, where rural residents were restricted to the countryside to work for those that lived in urban, industrialized zones as well as b) achieve its objectives for the purposes of continued urbanization. The continuation of the Hukou system, despite reform, is maintained for government purposes, and does not support or benefit migrants.

4.2.2 Problem 2: Economic Decentralization & the Structure of the Healthcare System

China's economic decentralization and liberalization brought about many changes to the country's political, economic, and social welfare. This not only impacted Hukou reform as discussed in the previous section, but also eventually altered various systems in the country, including the country's healthcare system. The country's healthcare system changed substantially after the economic reforms, with a dramatic reduction of the country's national health coverage. We learned that the government clawed back on its financial support provided to public hospitals

during the market reform period, which hiked up costs and fees associated with medical treatment, as well as the number of prescribed tests and prescriptions, and that physicians scrambled to both cover hospital costs and create profit, demonstrating that these reforms had a negative and costly impact (Whyte & Sun, 2010). The literature presented by Qui *et al.* (2011) expressed that due to the reduction in government expenditure on healthcare provision and services, physician income is largely dependent upon their earnings from patients. This incentivizes physicians to do things such as add a surcharge on existing fees, as well as tell patients that they require more imaging tests or additional medication. Zhang *et al.* (2015) found that in China, healthcare expenditures per visit increased from 987.1 RMB yuan in 2003 to 2,695.1 RMB yuan in 2012, which is a growth rate of 10.5% annually. They determined that this is due to supplier-induced demand (SID), which encourages patients to demand healthcare in excess of what is necessary, which is exploited as a result of what they deem an “information gap.” Zhang *et al.* (2015) also state that according to the Target Income Hypothesis and Benchmark model of Physicians’ Practice that SID is more often likely to occur when doctors’ target incomes are lower, or when their workloads are heavy.

While public hospitals should be primarily funded by the government, since the health system reforms in the 80’s, physicians have been encouraged to cover their expenses with profits from medical care due to the government’s financial strain. Government funding has plummeted dramatically, funding approximately 35% of the hospitals’ total revenue pre-reform to less than 10% in the 2010s. This is a problem for those who cannot afford treatment, and the information gap only exacerbates the exploitation of migrants and the poor in urbanized areas (Qui *et al.*, 2011).

The data in Tables 4.1.5 and 4.1.6 examine cost as a deterrent factor for seeking treatment for tuberculosis (Long *et al.*, 2011). Thus far, the research has established evidence that physicians recommend treatment beyond the period of free TB drugs, and pursue further tests such as repeat

imaging and blood tests, all of which require payment, and are added to the basic package of gratuitous care provided in the TB program as we saw in some of the qualitative statements in Chen *et al.*'s study (2015). Despite the central government's commitment to free TB treatment for patients who are registered at a local TB dispensary regardless of their Hukou status, healthcare providers have found further ways of generating revenue from patients diagnosed with TB (Long *et al.*, 2011). The TB treatment program does not cover hospitalization costs and any other additional drugs or examinations outside of the treatment program. Any additional costs should be covered by the individual's insurance and, for migrants, it has been identified that this poses two large problems.

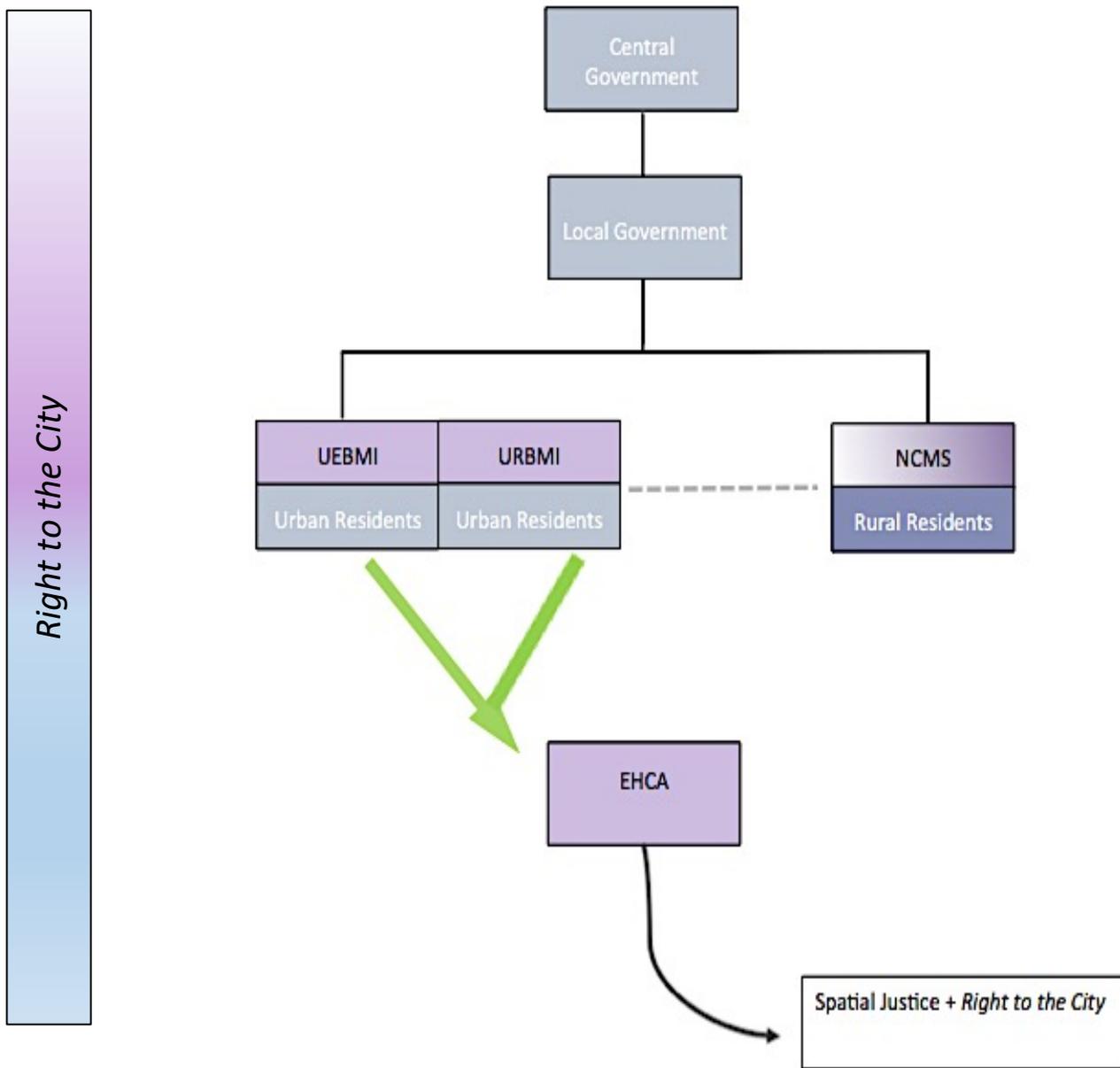
The first is that TB rates have proven to be higher in the migrant population. If doctors' revenues rely upon how they price and recommend medical treatment due to low government funding, they tend to increase prices, as well as tack on additional tests and prescriptions outside of the TB treatment plan. Therefore, migrants inevitably struggle to pay out of pocket. The second problem is that while the excess costs can be billed to one's insurance after the fact, the claim must correspond to the insurance scheme associated with the individual's Hukou, which, for a migrant, would be their rural Hukou, making claim submission and claim reimbursement through their NCMS insurance a lengthy and arduous process. This oftentimes disincentivizes migrants from either seeking or continuing their treatment course altogether, resulting in the recurrence of TB, and which encourages its spread, as well as its mutation to drug-resistant TB, making a more difficult form of TB even more difficult to treat in the long-run. This naturally poses ramifications on the individual's welfare, increasing worries about dealing with being ill, and interrupting their ability to work due to illness. This limits migrant capacity to live a full and healthy life, as well as limits their capacity to create better livelihoods, making escaping poverty difficult.

4.2.3 Problem 3: Equal Healthcare Access as Right to the city – Revisiting the Conceptual Framework

The last two sections have placed emphasis on the problems regarding the current relevancy of the Hukou system, as well as the inherent problems associated with the structure of China's healthcare system. The current structure of China's healthcare system is the result of the economic reforms that began in the late 70's, early 80's, which resulted in a sharp cut in government spending on healthcare. The current impact of the healthcare structure is a result of the Hukou system which we learned was only reformed, but not formally abolished by the Chinese government and which serves no real purpose other than the fulfillment of State interests, such as land acquisition and filling cheap labour to meet urbanization objectives. While the Hukou system might serve to benefit the government, it creates spatial injustice, blocking migrant access to what Henri Lefebvre refers to as a *right to the city*, as we were introduced to in Chapter 2. The overarching research question posed in Chapter 3 asks whether China's Hukou system is an impediment equal healthcare access, and the research sought to answer the question by exploring how the Hukou system, despite reform, impacts rural-to-urban migrant healthcare access, how it compares to those with urban Hukou, and how this spatial inequality created by the Hukou system infringes on migrants' *right to the city*. To determine whether we have successfully answered the research question, it would be apt to re-explore the conceptual model. If we review the initial explanation of the conceptual model, we can also revisit the relationships between the identified variables. The initial conceptual model aims to depict the conception of a spatial hierarchy between rural migrants and urban residents, and we can see that their access to equal healthcare is blocked, where Equal Healthcare Access (EHA) is identified as the path to the *right to the city* and spatial justice.

If we look at Figure 4.2 below, we can find an improved version of the original conceptual model initially presented in Figure 3.1.2. The original model helped to represent the problems inherent within the current structure of healthcare accessibility in China, which is based on Hukou status. This revised conceptual model aims to depict an improved, if not ideal, version of healthcare accessibility and Hukou policy. Like its predecessor, this conceptual model is structured vertically to represent a hierarchical structure as well as the administration of policy, and then horizontally to represent spatial justice. If we recall the original model, those with rural Hukou (NCMS) were spaced further apart from those in the urban Hukou category, and blocked from entering this category. In this version, we can observe that the path has been opened. The grey tracks leading directly into the urban sphere represent that rural residents are being phased in to acquire urban Hukou status. This is in direct reference to one of the primary goals of China's *New-Type Urbanization Plan (2016-2020)*, which, if we recall, is to integrate approximately 100 million rural residents into cities (Chan, 2014). This is a gradual integrative process spanning across four years, and the fading of the box containing those with rural Hukou aim to represent this gradual integration. Furthermore, we can observe that once rural residents are phased into urban Hukou, they are likely to first acquire insurance under the Urban Resident Basic Medical Insurance (URBMI) category since they do not have any professional skills in the public or private sectors. Upon acquiring urban Hukou and being fully integrated, the logic is that rural-to-urban migrants become unified with urban residents, and will also become an integral component to the urbanization process. Like the previous model, we can see that the green arrows represent equal healthcare accessibility, this time representing a more unified access to healthcare, thus equating to a *right to the city* for all, and therefore spatial justice.

Figure 4.2 – Conceptual Model: Revisited



Legend	
EHA	Equal Healthcare Access
NCMS	New Cooperative Medical Scheme
RTC	Right to the City
UEBMI	Urban Employee Basic Medical Insurance
URBMI	Urban Resident Basic Medical Insurance

If we review Lefebvre's articulation of his theory of the *right to the city*, Purcell, 2002 explains that Lefebvre imagines all decisions regarding urban development being a democratic deliberation in which the cultivation of urban space is not just limited to state decisions, but is inclusive to all, and that the restructuring of the power dynamics that underlie the production of urban space is necessary. Purcell elaborates further on Lefebvre's conceptualization of the *right to the city*, stating that this concept sees space in two ways: perceived space and conceived space (Purcell, 2002). The latter is important for our analysis, because we are concerned with rural migrants' mental and ontological experience during their integration into urban life. In the context of the *right to the city*, the constructs of space are important to migrants' capacity to partake in the production of urban space.

Soja's definition of spatial justice (2010: 62), marries well with Lefebvre's conception of the *right to the city* because for Soja, spatial justice is concerned with how social inequalities are brought into the spatial dynamics of urban areas, especially, and for our purposes, the ability for rural migrants to integrate and participate equally and freely to the dynamics of urban life and development. If migrants are limited by their Hukou status, which, as we have discovered, is difficult to change officially, they do not have the same equal right to social benefits as their urban counterparts, and thus have a limited capacity to participate equally in urban space. An individual who is disadvantaged as a result of the government's unwillingness to remove the major system that continues to marginalize one group over the other does not have spatial justice, and is limited in their contribution to the production of urban space. Maintaining the Hukou system makes equal healthcare access difficult for migrants since they cannot practically utilize their NCMS insurance. This puts migrants at a disadvantage when wanting to integrate freely within urban spaces, as well as when wanting to benefit from their right to social benefits provided by the state, such as

healthcare, and also impacts their perceived space. This results in the perpetuation of a spatial hierarchy, and therefore spatial injustice.

Chapter 5: Conclusion – Continued Reform for a Better Urban Future

5.1 Summary of the Research Findings

The objective of this research paper was to respond to the question of whether China's Hukou system implicates equal healthcare accessibility for rural migrants, and inevitably their *right to the city*. There are certainly some limitations to this research paper as expressed in the Introduction. Urbanization and the Hukou system are broad topics in themselves, and various research papers could be written on each of these topics exclusively. Furthermore, pertaining to the selection of tuberculosis as a case study to demonstrate the disparities between urban residents and rural-to-urban migrants, the research acknowledges that there are other topics in healthcare that would also be worthwhile exploring in contribution to the existing literature, such as disparities in maternal healthcare for rural-to-urban migrants, elderly care, and treatment for other infectious diseases such as H1N1 and HIV/AIDS; tuberculosis is just one of an array of potential healthcare issues to explore in illustration of the disparities in healthcare resulting from the Hukou system.

The findings gathered from the data responded to the research question. It did so by answering the three sub-questions, which were how the Hukou system, despite reform, still impacts rural migrant healthcare access, how migrant experience with healthcare access compares to those with urban Hukou, and how this spatial hierarchy created by the Hukou system compromises on migrants' *right to the city*. These questions were answered through a review of China's Hukou system, including a brief account of its history, legacy, reforms, and current implications, the evolution of urbanization, as well as through a review of the government's plans for the advancement of urbanization, such as with the country's *New-Type Urbanization Plan*. The responses to the research question were also facilitated through in-depth discussion on the

evolution and current structure of the country's healthcare system. The research has shown that China's healthcare is not easily accessible by rural-to-urban migrants, which was demonstrated in the data from various case studies on tuberculosis treatment access. The research paper has ultimately established that the preservation of the Hukou system, despite large reforms since the end of the Cultural Revolution, has only reformed, and has not made migrant lives easier when it comes to both urban integration and receiving social benefits. We have acknowledged that it is important to consider that while the Hukou system has reformed, it has not been removed, and that its current purpose only works to serve the government's agenda. As such, the preservation of the Hukou system maintains what the research defines as a spatial hierarchy initially utilized as a means to fulfill the objectives of socialism under Mao, by separating rural and urban residents. We have also determined that this spatial hierarchy between rural-to-urban migrants and urban residents is preserved despite reform, and we see can observe this in the differences of perceived and conceived space between migrants and urban residents.

It is clear that for migrants to have equal accessibility to social benefits, China's Hukou system must reform beyond its current extent of reform. The way in which the Hukou system operates is such that it would be counterproductive to sustain it while concurrently attempting to improve the distribution of social benefits, as well as rural-to-urban migrant integration. There has been experimentation with reform and gradual repeal of the Hukou system, such as by the Ministry of Commerce in 2001 which terminated the use of the "urban food-grain ration transfer certificate" (Chan & Buckingham, 2008), which was a fundamental document for obtaining what was considered a "migration permit" required for completing Hukou transfer (*nongzhuanfei*)⁷.

⁷ The core process for transferring rural to urban *hukou* in China for at least three decades (Chan & Buckingham, 2008).

However, new initiatives place emphasis on the required “entry conditions” stipulated by local governments, which would remain the principal function for regulating migration.

5.2 Challenges for Consideration

The focus of this research paper was on the Hukou system’s impact on healthcare administration and accessibility. However, the paper did not consider the question of removing Hukou policy altogether. The reason for this is that this question would have been beyond the scope and space of the research. Any attempt to answer this question would have been too brief to provide an extensive or quality review of such a possibility. However, in considering the removal of the Hukou system as the foundation of internal migration policy, it is important to consider the ramifications of its removal.

While it would be ideal to have no limitations on migration and mobility, as well as no categorized restrictions for administering social benefits, the immediate removal of the Hukou system would be disastrous. This is based on China’s population, and the current configuration of social policy, as we have seen. It can be argued that an immediate elimination of the system would result in too high a surge of migrants at once, and that it would therefore be apt to implement some form of policy easing through a phasing out of the Hukou system to gradually integrate all migrants into the system. China currently has a population of 1.37 billion (World Bank, 2016), with 44.3% of this population consisting of rural residents (World Bank, 2016). In transitioning the country from the categorical differences of rural and urban Hukou, it would be apt to design and implement a plan using a phasing methodology, such as integrating a certain number of existing rural residents at a time into the cities. This is best outlined in China’s *New-type Urbanization Plan (2016-2020)*, which plans to integrate approximately 100

million new urban residents from rural areas across the country. Alternatively, complete removal of the Hukou system would overload urban centres, both in terms of hard and soft infrastructure, such as transportation and feasible housing. We must also consider other components, such as integrating children into a classroom that is not overcrowded, not to mention social services, such as adequate healthcare that would not otherwise result in unfeasible wait-times and overcrowding. Since we know that removing the Hukou system is necessary for migrant integration and overall equality in the urban context, it is important to consider a resolution that would not jeopardize the context even further than it already has been, which is why the adoption of a phasing methodology is important to consider as a possibility.

Furthermore, it is important to consider the adoption of good governance practices for urban integration, not to mention a sustainable urban future. In a study on governance, Siddiqi *et al.* (2009) state that governance is fundamental to determining economic growth, social advancement, and a country's overall development. In improving healthcare accessibility, the publication identifies Health Systems Governance as crucial. It articulates that Health Systems Governance is concerned with the "actions and means adopted by a society to organize itself in the promotion and protection of the health of its population, [and that] this includes the institutions and organizations that operate within these rules to carry out the key functions of a health system" (Siddiqi *et al.*, 2009). This publication offers a very important consideration about the role of the ministries of health versus other state ministries, arguing that the governance of a health system should target the objective of health holistically rather than by just providing certain health services. The current structure of China's healthcare system does not place health in a holistic frame, but rather structures it with the Hukou system in mind, and this structure is further exploited by the current privatization of healthcare, which enables

healthcare practitioners to take advantage of patients, as we observed earlier on in the paper. The administration, accessibility, and the level of healthcare service is structured around an individual's Hukou classification, rather than their needs. In restructuring the healthcare system, and in implementing better governance practices to make healthcare more equally accessible for migrants, it is therefore important to consider what Sidiqqi *et al.* (2009) identify as simple health reform versus a human rights-based approach to health, in which the protection and promotion of health should be attained by both structural and managerial reforms, but also valuing health as an intrinsic human right. Any reforms to the healthcare system should thus ensure to look at Health Systems Governance practices for further reforms.

While it appears that, for now, at least, the Hukou system will not be repealed anytime soon, it is important to consider shared urban space, and the creation of an initiative that encourages that shared space. The consideration towards migrants must also change, beginning with not calling referring to them as *nongmingong*, since they are citizens of the country. We could also expect to see changes in the restructuring of China's healthcare policy, hoping that the country implements a system that is more centralized so that physicians can be paid equally for their expertise and time, so as not to make the poor and migrant groups suffer the disadvantages of a completely privatized healthcare system. Each of these recommendations are based on the considerations for sustainable and equal urban development in the country, as well for the benefit of disadvantaged groups. The hope is that in time, with continued reform and good governance practices as previously outlined, rural-to-urban will have equal access to all social benefits, and will be better able to integrate and contribute to a functioning, sustainable, and equal urban space.

References

- Adrian, Julie Ann Luiz, Tam Bang Vu, and Karla S. Hayashi. (2012). The New Cooperative Medical System in China: A Cure for All? *International Journal of Healthcare Information Systems and Informatics*, 7(3): 15-26. Accessed October 5, 2016. Doi: 10.4018/jhisi.2012070102.
- Afridi, Farzana, Sherry Xin Li and Yufei Ren. (2012). Social identity and inequality: The impact of China's Hukou system. *Journal of Public Economics* 123(2015): 17-29. Accessed April 24, 2016. Doi: 10.1016/j.jpubeco.2014.12.011.
- Andreas, Joel and Shaohua Zhan. (2015). Hukou and land: market reform and rural displacement in China. *The Journal of Peasant Studies* 1-30. Doi: 10.1080/03066150.2015.1078317.
- Babbie, E. R. (1999). The basics of social research. Belmont: Wadsworth/Thomson Learning.
- Banister, Judith. (1987). *China's Changing Population*. Stanford: Stanford University Press.
- Bell, Daniel A. (2010). From Communism to Confucianism: China's Alternative to Liberal Democracy. *New Perspectives Quarterly*, 27(2): 18-27. Accessed October 8, 2016. Doi: doi: 10.1111/j.1540-5842.2010.01151.x.
- Brenner, Neil. (2012). What is Critical Urban Theory? *City* 13(2-3): 198-207.
- Brenner, Neil, Peter Marcuse and Margit Mayer. (2009). Cities for people, not for profit, *City*, 13(2-3): 176-184.
- Bretzke, Wolf-Rüdiger Bretzke. (2013). Global urbanization: a major challenge for logistics. *Logistics Research* 6(2): 57-62. Accessed April 26, 2016. Doi: 10.1007/s12159-013-0101-9.
- Cai, Fang. (2011). Hukou System Reform and Unification of Rural-Urban Social Welfare, *China & World Economy*, 19(3): 33-48.
- Cao, Huhua, Zhao, Ying and Losier, Sylvain. (2000). « Le projet urbain de Pudong à Shanghai offre-t-il un développement durable pour la globalisation de la Chine? » (Does the Pudong Urban Project in Shanghai have a Sustainable Future?). *Les Annales de la recherche urbaine* 86: 92-100. Retrieved from: http://www.persee.fr/doc/aru_0180-930x_2000_num_86_1_2316.
- Cavanagh, Stephen. (1997). Content Analysis: Concepts, Methods, and Applications, *Nurse Researcher*, 4(3): 5-13. Accessed November 5, 2016. Doi: 10.7748/nr1997.04.4.3.5.c5869.
- Chan, Kam Wing. (2014). China's Urbanization 2020: A New Blueprint and Direction, *Eurasian Geography and Economics*, 55(1), 1-9. Document URL: <http://search.proquest.com.proxy.bib.uottawa.ca/docview/1718580598?accountid=14701>.
- Chan, Kam Wing. (2010). The Household Registration System and Migrant Labor in China: Notes on a Debate. *Population and Development Review* 36(2): 357-364. Doi: 10.1111/j.1728-4457.2010.00333.x.
- Chan, Kam Wing. (2009). The Hukou System at 50. *Eurasian Geography and Economics* 50(2): 197-221. Accessed April 27, 2016, doi: 10.2747/1539-7216.50.2.197.

- Chan, Kam Wing. (2009). Post-Mao China: A Two-Class Urban Society in the Making. *International Journal of Urban and Regional Research* 20(1): 134-150. Accessed April 28, 2016. Doi: 10.1111/j.1468-2427.1996.tb00305.x.
- Chang, Kam Wing and Will Buckingham. (2008). Is China Abolishing the Hukou System? *The China Quarterly* 195: 582-606. Accessed April 30, 2016. Doi: 10.1017/S0305741008000787.
- Chan, Kam and Li Zhang. (1999). The Hukou System and Rural-Urban Migration in China: Processes and Changes. *The China Quarterly* 160: 818-855. Accessed April 13, 2016. Doi: 10.1017/S0305741000001351.
- Chang, Kyung-Sup. (1994). Chinese urbanization and development before and after economic reform: A comparative reappraisal. *World Development* 22(4): 601-613. Accessed April 3, 2016. Doi: 10.1016/0305-750X(94)90115-5.
- Chan, Kam Wing and Kai Yuen Tsui. (1992). "Agricultural" and "Non-agricultural" Population Statistics of the People's Republic of China: Definitions, Findings and Comparisons. Hong Kong, University of Hong Kong, Department of Geography and Geology, Occasional Paper No. 1.
- Chen, Gang and Xiao Yan. (2012). Demand for voluntary basic medical insurance in urban China: panel evidence from the Urban Basic Medical Insurance scheme. *Health Policy and Planning* 27(8): 658-668. Accessed September 8, 2016. Doi: 10.1093/heapol/czs014.
- Chen, M. (2012). Modernity and confucian political philosophy in a globalized world. In F. Dallmayr & T. Zhao (eds.), *Contemporary chinese political thought: Debates and perspectives* (pp. 110 - 130). Kentucky: The University Press of Kentucky.
- Chen, Shanquan, Hui Zhang, Yao Pan, Qian Long, Li Xiang, Lan Yao, and Henry Lucas. (2015). Are free anti-tuberculosis drugs enough? An empirical study from three cities in China. *Infectious Diseases of Poverty* 4:47. Accessed November 7, 2018. Doi: 10.1186/s40249-015-0080-y/.
- Cheng, Tiejun and Mark Selden. (1994). The Origins and social Consequences of China's Hukou System. *The China Quarterly* 139: 644-668. Accessed April 15, 2016. Doi: 10.1017/S0305741000043083.
- The China Quarterly. (2000). Glossary of Chinese Terms. *The China Quarterly* 163: 908-913. Accessed April 25, 2016. Article Stable URL: <http://www.jstor.org/stable/655825>.
- Chung, Jae Ho and Tao-chiu Lam. (2004). China's "City System" in Flux: Explaining Post-Mao Administrative Changes. *The China Quarterly* 180: 945-964. Accessed April 27, 2016. doi: 10.1017/S0305741004000694.
- Congressional Executive Commission on China. (2016). "Freedom on Residence and Movement." *Congressional Executive Commission on China: Annual Report – 2016*. Retrieved from: <https://www.cecc.gov/publications/annual-reports/2016-annual-report>.
- Cooper, Ian. (2016). *Fragmented Social Exclusion and Rural-Urban Migration in China: A Case Study of Xi'an*. (Unpublished Doctoral Thesis) Carleton University, Ottawa, Canada. Accessed June 3, 2016. Identifier: <http://carletonu.summon.serialssolutions.com/2.0.0/linkd>.

- Cui, Rong and Jeffrey H. Cohen. (2015). Reform and the Hukou System in China, *Migration Letters*, 12(3): 327-335. Accessed April 24, 2016. ISSN: 1741-8984.
- Davin, Dalia. (2015). "Mao Zedong." *Oxford Bibliographies*. Accessed April 28, 2016, Doi: 10.1093/OBO/9780199920082-0037.
- Dong, Zhe and Michael Phillips. (2008). Evolution of China's Health-Care System. *The Lancet* 372(9651): 1715-6. Accessed October 1, 2016, ISSN: 01406736.
- Downe-Wambolt, Barbara. (1992). Content analysis: methods, applications, and issues. *Health Care for Women International*, 13(3): 313-321. Accessed November 5, 2016. Doi: 10.1080/07399339209516006.
- The Economist. (2012, April). "Urbanisation: Where China's future will happen." Retrieved from <http://www.economist.com/news/leaders/21601027-worlds-sake-and-its-own-china-needs-change-way-it-builds-and-runs-its>.
- Elo, Satu and Helvi Kygnäs. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1): 107-115. Accessed November 5, 2016. Doi: 10.1111/j.1365-2648.2007.04569.x.
- Fan, Jessie, Ming Wen, Lei Jin, and Guixin Wang. (2013). Disparities in Healthcare Utilization In China: Do Gender and Migration Status Matter? *Journal of Family and Economic Issues* 34(1): 52-63. Accessed September 18, 2016. Doi: 10.1007/s10834-012-9296-1.
- Fang, Kuangnan, Yefei Jiang, BenChang Shia, Shuangge Ma. (2012). Impact of Illness and Medical Expenditure on Household Consumptions: A Survey in Western China. *PLoS One* 7(12). Accessed September 15, 2016. Doi: 10.1371/journal.pone.0052928.
- Feng, W., P. Ren, Z. Shaokang, & S. Anan. (2005). Reproductive health status, knowledge, and access to health care among female migrants in Shanghai, China. *Journal of Biosocial Science* 37(05): 603-622. Accessed September 27, 2016. Doi: 10.1017/s0021932004006844.
- Fitzpatrick, Christopher, Zhang Hui, Wang Lixia, Li Renzhong, Ruan Yunzhou, Chen Mingting, Zhao Yanlin, Zhao Jin, Su Wei, Xu Caihong, Chen Cheng, Timothy Alston, Qu Yan, Lv Chengfei, Fu Yunting, Huan Shitong, Sun Qiang, Fabio Scano, Daniel P Chin, and Katherine Floyd. (2015). Cost-effectiveness of a comprehensive programme for drug-resistant tuberculosis in China. *Bulletin of the World Health Organization* 93(11): 775-784. Accessed October 7, 2016. Doi: 10.2471/BLT.14.146274.
- Food and Agricultural Organization: How to Feed the World. (2009). Global agriculture towards 2050. *High-Level Expert Forum*. Accessed April 29, 2016. Retrieved from http://www.fao.org/fileadmin/templates/wsfs/docs/Issues_papers/HLEF2050_Global_Agriculture.pdf.
- Fukuyama, F. (1995). Confucianism and democracy. *Journal of Democracy* 6(2): 20 - 33.
- Gang, Chen and Xiao Yan. (2012). Demand for Voluntary Basic Medical Insurance in Urban China: Panel Evidence from the Urban Basic Medical Insurance Scheme. *Health Policy and Planning*, 27(8): 658-668. Accessed October 4, 2016. DOI: 10.1093/heapol/czs014.
- Gong, Peter, Song Liang, Elizabeth J Carlton, et al. (2012). Urbanization and Health in China, *The Lancet* 379(9818): 843-852.

- Guan, Jian. (2011). Stigma towards the rural-to-urban migrants in China: A qualitative study. *An International Journal on Personal Relationships* 5: 21-37. Accessed January 19, 2016. ISSN: 1981-6472.
- Guan, Jian and Li Liu. (2014). Recasting Stigma as a Dialogical Concept: A Case Study of Rural-to-urban Migrants in China. *Journal of Community & Applied Social Psychology* 24(2): 75-85. Accessed May 12, 2016. Doi: doi: 10.1002/casp.2152.
- Gu, Chaolin, and Fulong Wu. (2010). Urbanization in China: Processes and Policies. *China Review* 10(1): 1-9. Accessed March 23, 2016. ISSN: 16802012.
- Hesketh, T., Jun, Y., Lu, L., & Mei, W. (2008). Health Status and Access to Health Care of Migrant Workers in China. *Public Health Reports*, 123(2): 189-197. Accessed May 19, 2016. ISSN: 00333549.
- Hong, Yan, Xiaoming Li, Bonita Stanton, Danhua Lin, Xiaoyi Fang, Mao Rong, and Jin Wang. Too Costly to be Ill: Healthcare Access and Health-Seeking Behaviours among Rural-to-Urban Migrants in China. *World Health & Population* 8(2): 22-34. Accessed August 24, 2016. PMID: 18277099.
- Hsieh, H.-F. and Shannon S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research* (15): 1277-1288.
- Huang, LQ, WB Wang, HD Li, B Xu, HX Yang. (2007). A descriptive study on diagnosis delays and factors impacting accessibility to diagnosis among TB patients floating population in Shanghai. *The Journal of Chinese Antituberculosis Association* 29: 127-129.
- Huntington, S. (1984). Will more countries become democratic? *Political Science Quarterly* 99(2): 193 - 218.
- International Organization for Migration: The UN Migration Agency. (2017). "China: Migrant Activities." Accessed January 12, 2017. Retrieved from: <https://www.iom.int/countries/china>.
- Johnson, Donald. (2014). China Rethinks Urbanization Its New Plan is a Big Policy Overhaul. *Planning* 80(10): 30, 32-35. Accessed April 28, 2016. ISSN: 00012610.
- Khaler, Christine. (2011). China's Healthcare Reform: How Far Has It Come? *The China Business Review* 38(1): 50-55. Accessed October 17, 2016. ISSN: 0163-7169.
- Knight, John, Lina Song and Kia Huaibin. (1999). Chinese rural migrants in urban enterprises: Three perspectives. *Journal of Development Studies* 35(3): 73-104. Accessed May 2, 2016. Doi: 10.1080/00220389908422574.
- Korolev, Alexander. (2014). *Deliberative Democracy Nationwide? – Evaluating Deliberativeness of Healthcare Reform in China* 19(2): 151-172. Accessed October 5, 2016. ISSN: 1080-6954.
- Kuang L, Liu L. (2012). Discrimination against Rural-to-Urban Migrants: The Role of the Hukou System in China. *PLoS ONE* 7(11): e46932. doi:10.1371/journal.pone.0046932.
- Lambert, ML and P Stuyft. (2005). Delays to tuberculosis treatment: shall we continue to blame the victim? *Tropical Medicine and International Health* 10(10): 945-946. Accessed October 7, 2016. Doi: 10.1111/j.1365-3156.2005.01485.x.

- Lefebvre, H. (1968). *Le droit à la ville*. Paris: Éditions Anthropos.
- Liang, Xiaoyun, Hong Guo, Chenggang Jin, Xiaoxa Peng, and Xiulan Zhang. (2012). The Effect of New Cooperative medical Scheme on Health Outcomes and Alleviating Catastrophic Health Expenditure in China: A Systematic Review. *PLoS One* 7(8). Accessed November 2, 2016. Doi: 10.1371/journal.pone.0040850Liang, Xiaoyun, Hong Guo, Chenggang Jin, Xiaoxa Peng, and Xiulan Zhang (2012). The Effect
- Lieberthal, Kenneth G. (2016). "Cultural Revolution." *Encyclopedia Britannica*. Accessed April 28, 2016. Retrieved from: <https://www.britannica.com/event/Cultural-Revolution>.
- Li, L. (2011). The Challenges of Healthcare Reforms in China. *Public Health* 125(1): 6-8 Accessed September 29, 2016. ISSN: 0033-3506.
- Li, Lan Angela. (2015). The edge of expertise: Representing barefoot doctors in Cultural Revolution China 39(3-4): 160-167. Accessed August 25, 2016. Doi: 10.1016/j.endeavour.2015.05.007.
- Li, Xiaoming, Bonita Stanton, Xinguang Chen, Yan Hang, Xiaoyi Fang, Danhua Lin, Romg Mao, and Jin Wang. (2006). Health Indicators and Geographic Mobility among Young Rural-to-Urban Migrants in China. *World Health Population* 8(2): 5-21. Accessed September 9, 2016. PMID: 18277098.
- Li, Xinxu, Shiwen Jiang, Xue Li, Jian Mei, Qiu Zhong, Wieguo Xu, Jun Li, Weibin Li, Xiaqiu Liu, Hui Zhang, Lixia Wang. (2012). Predictors of Delay of Initial Health-Seeking in New Pulmonary Tuberculosis Cases Among Migrant Populations in East Asia. *Plus One* 7(2). Accessed October 3, 2016. Doi: doi.org/10.1371/journal.pone.0031995.
- Ling, R.E, F. Liu, X.Q Lu, W. Wang. (2011). Emerging issues in public health: A perspective on China's healthcare system. *Public Health* 125(1): 9-14. Accessed August 28, 2016. Doi: 10.1016/j.puhe.2010.10.009.
- Liu, Hong and Zhao Zhong. (2014). Does health insurance matter? Evidence from China's urban resident basic medical insurance. *Journal of Comparative Economics* 42(4): 1007-1020. Accessed September 10, 2016. Doi: 10.1016/j.jce.2014.02.003.
- Liu, Ran, Wong Tai-Chee, Liu Sheng. (2013). Low-wage migrants in northwestern Beijing, China: The hikers in the urbanization and growth process. *Asian Pacific Viewpoint* 54(3): 352-371. Accessed May 9, 2016. Doi: doi: 10.1111/apv.12029.
- Long, Qian, Helen Smith, Tuohong Zhang, Shenglan Tang, and Paul Garner. (2011). Patient medical costs for tuberculosis treatment and impact on adherence in China: a systematic review. *BMC Public Health* 11(393). Accessed October 14, 2016. Doi: 10.1186/1471-2458-11-393.
- Long, Qian, Ying Li, Yang Wang, Yong Yue, Cheng Tang, Shenglan Tang, S Bertel Squire, and Rachel Tolhurst. (2008). Barriers to accessing TB diagnosis for rural-to-urban migrants with chronic cough in Chongqing, China: A mixed methods study. *BMC Health Services Research*, 8(202). Accessed October 8, 2016. Retrieved from: <http://bmchealthservres.biomedcentral.com.proxy.bib.uottawa.ca/articles/10.1186/1472-6963-8-202>.

- Lu, Xing. (2014). Rhetoric of Legitimacy: Comparing Han Yu's Defense of Confucianism and Mao Zedong's Justification of the Communist Rule (Essay). *China Media Research* 10(4): 101(10). Accessed April 19, 2016. ISSN: 1556-889X.
- McGee, T.G., George C.S. Lin, Andrew M. Marton, Mark Y. L. Wang, Jiaping Wu. (2007). *China's Urban Space: Development under market socialism*. New York: Routledge.
- Milcent, Carine. (2010). Healthcare for migrants in urban China: A New Frontier, *China Perspectives*, 4(149): 33-46. Accessed April 24, 2016. ISSN: 20703449.
- Mingchao, Zhou and Peter Brown. (2016). Living in the City: The Identity Strategies of Schoolchildren in an Urban Setting Confronted by the Stigma of Being "Children of Nongmingong." *China Perspectives*. Accessed July 26, 2016. ISSN: 2070-3449.
- Mote, Frederick W. (2003) *Imperial China 900-1800* (Illustrated ed.). Boston: Harvard University Press.
- Mou, J., Cheng, J., Zhang, D., Jiang, H., Lin, L., & Griffiths, S. M. (2009) Health care utilization amongst Shenzhen migrant workers: Does being insured make a difference? *BMC Health Services Research*, 9(1), 214.
- Muller, Armin. (2016). Hukou and health insurance coverage for migrant workers. *Journal of Current Chinese Affairs*, 45(2): 53(30). Accessed January 12, 2017. ISN: 1868-1026.
- New, Peter Kong-Ming and Mary Louie New. (1975). Health Care in the People's Republic of China: The Barefoot Doctor. *Inquiry*, 12(2): 103-113. Accessed October 4, 2016.
- Pan, Jay, Sen Tian, Qin Zhou, and Wei Han. (2016). Benefit Distribution of Social Health Insurance: Evidence from China's Urban Resident Basic Medical Insurance. *Health Policy and Planning*, 31(7): 853-859. Doi: 10.1093/heapol/czv141.
- Peng, Yingchun, Wenhua Chang, Haiqing Zhou, Hongpu Hu, and Wanninan Liang. (2010). Factors associated with health-seeking behavior among migrant workers in Beijing, China. *BMC Health Services Research* 10: 69-69. Accessed October 3, 2016. Doi: 10.1186/1472-6963-10-69.
- Purcell, M. (2002) Excavating Lefebvre: The *Right to the city* and its Urban Politics of the Inhabitant. *GeoJournal* 58(203): 99-108.
- Qianhan, Lin. (2013). Lost in Transformation? The Employment Trajectories of China's Cultural Revolution Cohort. *The Annals of the American Academy of Political Science*, 646(1): 172-193.
- Qiu, Renzong. (2012). Healthcare Sector Reform in Mainland China. *Journal International de Bioéthique* 2(23): 15-24. Accessed October 9, 2016. DOI:10.3917/jib.232.0015.
- QSR International. (2017). "What is NVivo?" Retrieved from <http://www.qsrinternational.com/what-is-nvivo>.
- Schreier, Margrit. (2012). *Qualitative Content Analysis in Practice*. London; Thousand Oaks/Sage Publications.

- Shao, Yongyu. (2016). Current State of China's National New-Type Urbanization Construction and Deployment of New Reinforcement Measures: Overview of the Implementation Status of the Plan and Outlook of the Effects of New Promotion Measures. *Mizuho Bank*. Accessed January 17, 2017. Retrieved from: <https://www.mizuhobank.com/service/global/cndb/economics/monthly/pdf/R512-0079-XF-0103.pdf>.
- Shaokang, Zhan, Sun Zhenwei, and Erik Blas. (2002). Economic transition and maternal health care for internal migrants in Shanghai, China. *Health policy and Planning* 17(1): 47-55. Accessed October 5, 2016. ISSN: 02681080.
- Shenglan Tang and Stephen Bertel Squire. (2005). What lessons can be drawn from tuberculosis (TB) Control in China in the 1990s? An analysis from a health system perspective. *Health Policy* 72: 93-104. Accessed September 20, 2016. Doi: doi:10.1016/j.healthpol.2004.06.009.
- Siddiqi, Sameen, Tayeeb I. Masud, Sania Nishtar, David H. Peters, Belgacem Sabrina, Khalif M. Bile, Mohamed A. Jama. (2009). Framework for assessing governance of the health system in developing countries; Gateway to good governance. *Health Policy* 90(1): 13-25. Accessed January 12, 2017. Doi: 10.1016/j.healthpol.2008.08.005.
- Snyder, Madeline. (2014). Pill too Big to Swallow: Challenges in Chinese Health Care. *Harvard International Review* 36(2): 11(2). Accessed October 23, 2016. ISSN: 0739-1854.
- Soja, E. (2010). *Seeking Spatial Justice*. Minneapolis, Minnesota. Retrieved from Scholars Portal.
- Taylor, John. (2015). The China Dream is an Urban Dream: Assessing the CPC's National New-Type Urbanization Plan. *Journal of Chinese Political Science* 20: 107-120. Accessed April 30, 2016. DOI: 10.1007/s11366-015-9341-7.
- The United Nations. (2014). "World Urbanization Prospects: Highlights." *Department of Economic and Social Affairs*. Retrieved June 12, 2016 from <https://esa.un.org/unpd/wup/publications/files/wup2014-highlights.Pdf>. ISBN ISBN 978-92-1-123195-3.
- Tseng, Roy. (2016). "The idea of freedom in comparative perspective: critical comparisons between the discourses of liberalism and neo-Confucianism." *Philosophy East and West* 66(2): 539(20). Accessed April 10, 2017. ISSN: 0031-8221.
- Valentine, Vikki. (2005). Health for the Masses: China's "Barefoot Doctors." *Global Health*.
- Wang, C.Y (2014). China: Planning for an Urban Future in *EY: Building a Better Working World*. Accessed August 5, 2016. Retrieved from <https://www.cecc.gov/publications/annual-reports/2016-annual-report>.
- Wang, Feng and Zuejin Zuo. (1999). Inside China's cities: Institutional barriers and opportunities for urban migrants. *The American Economic Review* 89: 276-280. Accessed January 18, 2016. Article Stable URL: <http://www.jstor.org/stable/117120>.
- Wang, Wenfei Winnie and C. Cindy Fan. (2012). Migrants workers' intergration in urban China: Experiences in employment, social adaptation, and self-identity. *Eurasian Geography and Economics* 53: 731-749. Accessed January 15, 2016. Doi: 10.2747/1539-7216.53.6.731.
- Wang, Lixia, Hui Zhang, Yunzhou Ruan, Daniel P Chin, Yinyin Xia, Shiming Cheng, Mingting

- Chen, Yanlin Zhao, Shiwen Jiang, Xin Du, Guangxue He, Jun Li, Shengfen Wang, Wei Chen, Caihong Xu, Fei Huang, Xiaqiu Liu, Yu Wang. (2014). Tuberculosis prevalence in China, 1990-2010; a longitudinal analysis of national survey data. *The Lancet* 383(9934): 2057-2064. Accessed August 8, 2016: doi: 10.1016/S0140-6736(13)62639-2.
- Wang, W., J. Wang, Q. Zhao, N.D Darling, M. Yu, B. Zhou, and B. Xu. (2011). Contribution of rural-to-urban migration in the prevalence of drug resistant tuberculosis in China. *European Journal of Clinical Microbiology & Infectious Diseases* 30(4): 581-586. Accessed October 17, 2016. Doi: 10.1007/s10096-010-1125-6.
- Wang, Xin-Rui, Eddie Chi-Man Hui, Charles Choguill and Sheng-Hua Jia. (2015). The new urbanization policy in China: Which way forward? *Habitat International* 47. (2015): 279-284. Accessed April 24, 2016. Article Stable URL: <http://dx.doi.org/10.1016/j.habitatint.2015.02.001>.
- Wang, Yang, Qian Long, Qin Liu, Rachel Tolhurst and Shenglan Tang. (2008). Treatment seeking for symptoms suggestive of TB: comparison between migrants and permanent urban residents in Chongqing, China. *Tropical Medicine & International Health* 13(7): 927-933. Accessed October 4, 2016. Doi: 10.1111/j.1365-3156.2008.02093.x.
- Watts, Jonathan. (2008). Chen Zhu: From Barefoot Doctor to China's Minister of Health. *The Lancet* 372(9648): 1455. Accessed September 28, 2016. DOI: 10.1016/S0140-6736(08)61355-0.
- Whyte, Martin and Zhongxin Sun. (2010). The impact of China's market reforms on the health of Chinese citizens: examining two puzzles. *China* 8(1): 1-32. Accessed August 23, 2016. ISSN: 0219-7472.
- The World Bank Data Bank. (2016). In *Urban Population (% of total)*. Accessed May 1, 2016 from <http://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS>.
- The World Health Organization: WHO Representative Office, China. (2016). Tuberculosis in China. Accessed April 29, 2016 from <http://www.wpro.who.int/china/mediacentre/factsheets/tuberculosis/en/>.
- Wei, Xiaolin, Guanyang Zou, John Walley, Jia Yin, Knut Lonnroth, Mukund Uplekar, Weibing Wang, and Qiang Sun. (2014). China Tuberculosis Policy at Crucial Crossroads: Comparing the Practice of Different Hospital and Tuberculosis Control Collaboration Models Using Survey Data. *PLoS One* 9(3): 1-8. Accessed April 27, 2016. Doi: 10.1371/journal.pone.0090596.
- Weiler, Leah. (2015). *Navigating ethnic identity in neighbourhoods of difference: Resident perceptions of urban space in Urumqi, China* (Unpublished Masters thesis). University of Ottawa, Ottawa, Canada. Identifier: <http://hdl.handle.net/10393/32498>.
- Witton, Agnieszka. (2013). Economic Effects of the Urbanization Process in China. *Entrepreneurial Business and Economics Review* 1(3): 57- 69. Accessed April 27, 2016. ISSN: 2353883X.
- World Bank. (2016). "China" in "Data." Accessed January 6, 2017. Retrieved from: <http://data.worldbank.org/country/china>.
- Wu, Xiagang and Xi Song. (2014). Ethnicity, migration, and social stratification in China:

- Evidence from Xinjiang Uighur Autonomous Region. *Social Science Research* 44: 158-172. Accessed January 19, 2016. Doi: 10.1016/j.ssresearch.2013.12.002.
- Xu, Chenggang. (2011). The Fundamental Institutions of China's Reforms and Development. *Journal of Economic Literature* 49(4): 1076-1151. Accessed April 28, 2016. ISSN: 00220515.
- Xu, Zhun. (2013). The political economy of decollectivization in China. *Monthly Review* 65(11), 17-19. Accessed April 26, 2016. ISSN: 0027-0520.
- Xun, Zhou. (2016). Reconsidering the Barefoot Doctor Programme. *Fudan Journal of the Humanities and Social Sciences* 9(1): 41-63. Accessed October 5, 2016. DOI: 10.1007/s40647-015-0107-6. ISSN: 00469580.
- Yang, Rong Yang, Donald P McManus, Darren J Gray, Xiao Ling Wang, Shu Kun Yang, Allen G Ross, Gail M Williams and Magda K Ellis. (2012). Evaluation of the tuberculosis programme in Ningxia Hui Autonomous region, the People's Republic of China: a retrospective case study 12(1): 1110. Accessed December 5, 2016. Doi: 0.1186/1471-2458-12-1110.
- Yi, Hu, Barun Mathema, Wieli Jiang, Barry Kreiswirth, Wiebin Wang and Biao Xu. (2011). Transmission Pattern of Drug-Resistant Tuberculosis and Its Implication for Tuberculosis Control in Eastern Rural China. *PLoS One* 6(5). Accessed January 4, 2017. Doi: 10.1371/journal.pone.0019548.
- Young, Jason. *China's Hukou System: Markets, Migrants, and Institutional Change*. (2013) Palgrave MacMillan.
- Zhang, Daqin and Paul U Unschuld. (2008). China's Barefoot Doctor: Past, Present, and Future. *The Lancet* 372(9653): 1885-1867. Accessed October 2, 2016. DOI: 10.1016/S0140-6736(08)61355-0.
- Zhang, Huaifeng. (2010). The Hukou system's constraints on migrant workers' job mobility in Chinese cities. *China Economic Review* 21(1): 51-64. Accessed October 14, 2016. Doi:10.1016/j.chieco.2009.10.002.
- Zhang, Li and Li Tao. (2012). Barriers to the Acquisition of Urban Hukou in Chinese Cities, *Environment and Planning A*, 44(12): 2883-2900.
- Zhao, Hao, Huimei Hu, Christina Wu, Hai Yu, and Hengjin Dong. (2015). Impact of China's Public Hospital Reform on Healthcare Expenditures and Utilization: A Case Study in ZJ Province. *PLoS One* 10(11). Accessed October 17, 2016. Doi: doi.org/10.1371/journal.pone.0143130.
- Zhao, Yinjun, Bowei Kang, Yawan Liu, Yichong Li, Guoqing Shi, Tao Shen, Yong, Jiang, mei Zhang, Maigeng Zhou and Limin Wang. (2014). Health Insurance Coverage and its Impact on Medical Cost: Observations from the Floating Population in China. *PLoS One* 9(11): e111555. Doi: 10.1371/journal.pone.0111555.
- Zheng, Jiazhi, Leiyu Shi, Xia Zou, Wen Chen, and Li Ling. (2015). Rural-to-Urban Migrants' Experiences with Primary Care under Different Types of Medical Institutions in Guangzhou, China. *PLoS One* 10(10): 1-21. Accessed April 27, 2016. Doi: 10.1371/journal.pone.0140922.
- Zheng, Xinye, Jing Wang, Xilu Li, and Yihua Yu. (2015). On the Supply of China's Healthcare Resources in a Decentralized Healthcare System. *The Social Science Journal* 52(4): 449-458. Accessed October 3, 2016. DOI: 10.1016/j.soscij.2014.05.003.

- Zhou, Xun. (2016). Reconsidering the Barefoot Doctor Programme. *Fudan Journal of the Humanities and Social Sciences* 9(1): 41-63. Accessed August 23, 2016. Doi: 10.1007/s40647-015-0107-6.
- Zhou, Zhongliang, Zhiying Zhou, Jianmin Gao, Xiawei Yang, Ju'E Yan, Qingiang Xue, and Gang Chen. (2014). The Effect of Urban Basic Medical Insurance on Health Service Utilization in Shaanxi Province, China: A Comparison of Two Schemes. *PlusOne* 9(4): 1-12. Accessed October 2, 2016. ISSN:1932-6203.
- Zhu, Yu and Wenzhe Chen. (2010). Floating Population in the Cities: Recent Changes and Multifaceted Individual-Level Determinants. *Population, Space and Place* 16(4): 253-267. Accessed October 2, 2016. DOI: 10.1002/psp.